

Long-term, sustainable financing is a major challenge for the majority of multisector partnerships, and the organizations aligned with them, in regions across the country. Many depend overwhelmingly on short-term sources of funding—namely, grants. It's time to explore new financing frontiers!

BEYOND THE Grant

A Sustainable Financing Workbook



ReThink
Health®
A RIPPEL INITIATIVE

by **Lindsey Alexander and Stacy Becker**
with Katherine Wright and Kim Farris-Berg

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Table of Contents

It's high time to open new doors to sustainable financing structures. Take a minute to find out how to get ready.

Is this book for you? (Probably!) Find out what it can do for you and your multisector partnership or organization.

Right now, there's a lot of money flowing through your region (trust us: a LOT). If you could capture just a sliver of that, you could make some serious progress. How do you do that? Well, let's start by exploring how others have done it.

Systems, systems thinking, systems-oriented . . . enough already! What the heck is a system anyway? Find out how understanding it can help your partnership or organization achieve its goals.

Got grants? Great! Now let's talk about some other funding sources and see which ones are right for your partnership or organization!

Creating a financial plan sounds daunting, but it's really important (and painless, we promise!). You'll gain insight into your work just by trying. Don't worry if you don't know the numbers—just dive in!

You know your work is valuable, but how do you demonstrate that to others? ReThink Health's Value Sequence can help you identify the value you create, add evidence, and successfully "make the case" for funding.

Yes, your collaboration can charge for the services it provides! But how do you even begin to decide what amount to charge? It's not as hard as it sounds.

"Integrative activities" used to be thought of as coordinating work done by "backbone" organizations. But many organizations share the task of governing and managing collective efforts, and these tasks can be the hardest to fund. Explore the different integrative activities and find out how other partnerships fund theirs!

Let's wrap things up and take a moment to thank those who made this workbook possible.

Cracking open the workbook and seeing some terms you don't recognize? You're not alone, so we've put together this glossary. Refer to it as needed while you explore the workbook!

Want a reference for what integrative activities are and how to demonstrate their value? How about more details on financing structures? We've got you covered!



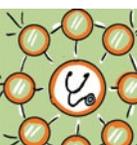
PREFACE Before You Dive In



INTRODUCTION What Is This Thing? Will It Really Help You Finance Your Work?



MODULE 1 How Do You Move Money Across Sectors and Organizations?



MODULE 2 What is a System (And How Does It Influence Who Wins and Loses)?



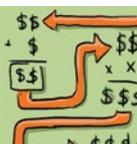
MODULE 3 Where Can You Find Money for Your Work (And How Do You Get It)?



MODULE 4 How Much Will Your Dreams Cost (And How Do You Estimate Those Costs)?



MODULE 5 What Value Do You Create?



MODULE 6 How Much Should You Charge for Your Services?



MODULE 7 What Integrative Activities Could You Get Paid For?



CONCLUSION / ACKNOWLEDGEMENTS Some Final Thoughts—and Many Thanks!



GLOSSARY Let's Get on the Same Page about Terminology.



APPENDICES The Nitty-Gritty of Integrative Activities and Financing Structures.

Looking for a specific worksheet or resource, perhaps to print or copy to share with colleagues?

Here's a handy list!



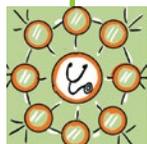
INTRODUCTION

RESOURCE | **What are Integrative Activities?**



MODULE 1

WORKSHEET | **Influencing Financial Flows**



MODULE 2

WORKSHEET | **Exploring Your System**

WORKSHEET | **Considering Costs and Benefits**

- **Worksheet Instructions**
- **Sheets** (print on 11" x 17" paper)



MODULE 3

WORKSHEET | **Exploring Financing Structures**

RESOURCE | **A Typology of Potential Financing Structures for Population Health**
(print on 11" x 17" paper)



MODULE 4

WORKSHEET | **Financial Planning Template** (Basic)

RESOURCE | **The Financing Wizard**

is digital only, and on the web at:

<https://www.rethinkhealth.org/financingworkbook/Financing-Wizard>



MODULE 5

WORKSHEET | **Value Analysis**

RESOURCE | **Value Sequence Template**
(print on 11" x 17" paper)



MODULE 7

WORKSHEET | **What Integrative Activities Could You Get Paid For?**



APPENDICES

APPENDIX 1 | **Integrative Activities**

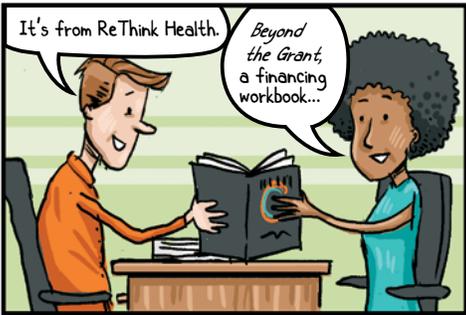
APPENDIX 2 | **Integrative Activities Evidence**

APPENDIX 3 | **Financing Structures for Population Health**



Before You Dive In

PREFACE



It's high time to open new doors to sustainable financing structures. Take a minute to find out how to get ready.



Before You Dive In

Let's try something: imagine for a moment that the only way communities could finance investments in affordable housing or community development was through grants—and no other financing alternatives, such as low-income housing tax credits, Section 8 vouchers, or community development finance institutions, were available. The truth is, without the benefit of alternative financing options, it would be nearly impossible for communities to revitalize neighborhoods or produce a significant number of affordable housing units.

Both community development and population health efforts endeavor to address critical social needs, yet the former has established a variety of sources of funding that are both *sustainable* and *dedicated*. Sustainable means that the source provides revenue over the long-term (think 15-20 years or more—way beyond a typical grant cycle of three-to-five years!). Dedicated, in this case, means it provides a source of funding specifically for population health that is available across many regions.

Without these sustainable or dedicated sources, population health efforts depend almost exclusively on grants. In fact, according to [ReThink Health's 2016 Pulse Check on Multisector Partnerships survey](https://www.rethinkhealth.org/tools/pulse-check/)¹, 89 percent of multisector partnerships addressing health and well-being rely on grants, with only slight use of any financing options that might be considered more sustainable. Don't get us wrong: it's not that grants are bad! In fact, population health couldn't have gotten to where it is now without them. It is, however, unrealistic to expect grants to fund all of the impressive population health work happening in our communities, indefinitely.

Where are the dedicated, widely-available sources of funding for population health?

They don't exist yet.

However, there are emerging efforts to address this deficit. ReThink Health, for example, is investigating models of reinvestment as well as tax credits for population health. In the meantime, you do have options—and this workbook can help you tap into them.



Work is being done—by ReThink Health and other like-minded organizations—on the policy level to create more doorways to sustainable and dedicated funding sources for population health.



Opening New Doors

As someone working to improve population health and well-being, you've probably seen or heard about other cities and regions that have opened doors to innovative sources of funding: sugar-sweetened beverage taxes, new payment models, or even public appropriations (for more, see [A Typology of Potential Financing Structures for Population Health](#) in [Module 3](#)). But those examples seem exceptional rather than the norm, and it probably feels like most of those doors are closed to you. You may feel like the only open door leads to grants, but that doorway is jammed with countless other organizations competing for limited grant dollars.

So while there aren't yet dedicated sources of sustainable funding widely available for population health, there is good news. There are doors that lead to sources of funding that are *more* sustainable. And work is being done—by ReThink Health

¹ <https://www.rethinkhealth.org/tools/pulse-check/>



and other like-minded organizations—on the policy level to create more doorways to sustainable and dedicated funding sources for population health. While it will likely take a number of years before those sources materialize, you do have options. You *already* are doing valuable work, and community leaders and policy makers are taking notice. While this workbook cannot create a magical source of funding for you, it can help you pick the locks on new doors to finance your work *in the meantime* and ensure you are prepared to take advantage of what's ahead. Don't get stuck waiting for someone else to open the doors for you; you can make valuable progress with what's available now. You just have to trust in your abilities and get started—and we've designed this workbook to help.

Getting Started

You don't need a special password or knowledge before you dig into this workbook, but we do want to be sure you bring a few things to this material so you can make the most of it.

A specific use. Much of this material asks you to know what *specific activity(s)* you want to finance. This could be a specific intervention(s), or your integrative activities. It's perfectly fine to use an idea that is half-baked or invent something to use as an example. But you'll get more out of this material if you *know what you want to potentially spend money on*; otherwise, you won't have the details necessary to complete the exercises. That said, we're fully in support of just reading the workbook to get smarter about financing in general or gain a sense for how the various tools might help you. And, in those cases, a specific use is less important. But again, if you're looking to apply the material, it will help you immensely to get clear on what, exactly, you're looking to pay for.

One multisector partnership or organization at a time. We know that within some communities or regions there is more than one effort focused on improving the population's health and well-being. If you work with more than one organization or multisector partnership, then you will need to identify which organization's activities you're exploring in order to get the most from this workbook. This is particularly relevant if you're coming to this workbook with questions about financing your integrative activities. If you try to engage with the material but are unclear on which organization's perspective you are considering (e.g., you are a member of both a Pre-K collaboration and a regional health collaboration and you try to represent both perspectives in your answers), you will quickly find yourself frustrated or confused. (If you want to take up the activities or perspectives of different organizations, just go through the material twice—one organization at a time.)

Dedication and willingness to do the work. Beverly Sills, a famous American opera singer, once said *there are no shortcuts to any place worth going*. This workbook offers a practical set of tools to help advance your financing, but it is not a magical black box that allows you to plug a couple of grants in one side and sustainable financing pops out the other (but someone really should invent that!). We'll walk you through the key questions, but you have to apply your experience and ambition (and a little bit of elbow grease) to generate the answers. You also have to believe strongly in the value your partnership creates and your ability to finance it; after all, if you don't, why should anyone else? Give the workbook exercises enough time so you don't short-change the discussions (and your organization in the process). Put in the time and effort and this workbook will help you decide where your hard work will have the most impact.

“ There are no shortcuts to any place worth going.

Checklist

READINESS

Do you have a specific use (intervention, integrative activities, etc.) in mind—even if it’s “half-baked” or simply a way to explore the material? YES NO

Have you identified which one organization you’ll be representing? YES NO

Are you ready to roll up your sleeves? YES NO

If you answered “yes” to all of these questions you are ready to get started! If you didn’t, you can still skim this workbook to learn more about financing in general.

A few more things . . .

- 1 Ground yourself in the Financing Mindset** (see [Introduction](#), page 6). The way you think about financing *matters*. A Financing Mindset opens your mind to the opportunities all around you. Try to fully incorporate this mindset into your work.
- 2 Your new mantra: I. Am. Doing. Valuable. Work.** Say it again. *I am doing valuable work*. Don’t worry if it’s just a hunch right now. This workbook—specifically [Module 5: What Value Do You Create?](#)—can help you become skilled at explaining where and how your partnership creates value. But for now, you need to be confident that your organization is already making a difference.
- 3 You are an expert.** Population health is a relatively young endeavor; the financing of it is embryonic. This workbook (particularly [A Typology of Potential Financing Structures for Population Health](#) in [Module 3](#)) suggests several sustainable sources of funding. But remember that you—as a practitioner in the field—understand your work better than anyone. You are in the best position to identify financing opportunities woven in and around your work. Don’t wait for others to invent more or easier solutions; get out and start trying to crack open new doors! (You might even discover a new door!) Your efforts can help identify solutions for others and move population health to new frontiers.
- 4 Iteration is to be expected.** Many of the exercises are stepwise and linear, and we’ll walk you through those steps. However, you’ll likely uncover information at different points in the process that impact earlier decisions or conversations. That’s to be expected. Don’t be afraid to take a step back and revisit or start an exercise over again. It’s like cooking. You have your recipe and you follow the steps, but you taste, react, and adjust as you go. (And when all else fails, you just start over!)

“ Don’t be afraid to take a step back and revisit or start an exercise over again. It’s like cooking. You have your recipe and you follow the steps, but you taste, react, and adjust as you go. (And when all else fails, you just start over!)





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What Is This Thing? Will It Really Help You Finance Your Work?

INTRODUCTION



Is this book for you? (Probably!) Find out what it can do for you and your multisector partnership or organization.

What Is This Thing? Will It Really Help You Finance Your Work?

You are only a few words into this financing workbook and likely wondering:

- 1 “what is this?” and
- 2 “will it really help me finance my work?”

To answer your questions:

- 1 this workbook is a tool that will step you through a handful of key exercises to clarify and troubleshoot your financing strategy, and
- 2 yes! Everything in this book has been tested by people just like you, and, according to them it has indeed helped.

This workbook is designed for anyone who has questions about financing their efforts to improve health and well-being in their region. In particular, we approach it from the perspective of multisector partnerships and organizations that want to pursue transformative change, and assume you are working on behalf of one of those (though even if you aren't, you can still learn a lot about financing here). Whether you want to fund an intervention, create a financial plan for a collaboration across groups, or get paid for your group's integrative activities—or just get smart about financing!—this workbook can offer guidance.

While you'll still get plenty from the workbook no matter what your partnership or organization's goals, you'll get the most out of it if you approach it the same way we have: from the perspective of health system transformation. That means looking at all the factors influencing health in your region as part of an interlocking system, then seeking to tackle challenges by changing that system—uprooting the problems at their source, rather than simply treating the *symptoms* of systemic problems. Health system transformation is characterized by a willingness to pioneer innovative solutions, forge new relationships, and discard the status quo if it's not working well enough.

There are hundreds of multisector partnerships and organizations throughout the country. Most of them are fairly early in their development¹ and even more of them depend heavily on short-term, temporary funding sources—namely, grants. Long-term, sustainable financing is a major challenge².

With that in mind, we at ReThink Health (an initiative of The Rippel Foundation) set out to create a workbook that would demystify financing and give multisector partnerships and organizations a handful of practical, user-friendly tools to help them see financing in a new light and create an action plan for moving *beyond the grant*.

¹ <https://www.rethinkhealth.org/the-rethinkers-blog/multi-sector-partnerships-have-the-potential-to-transform-health-but-most-arent-there-yet/>

² We promise not to have too many footnotes, but we thought you might want to know how we know this. As part of our work with cross-sector collaboratives around the country, ReThink Health conducts a bi-annual Pulse Check survey to explore what they do, how they finance their work, and how these groups have been developing over time. The 2016 results can be found here: <https://www.rethinkhealth.org/tools/pulse-check/>.





Financing is the process of balancing sources & uses

The term “finance” or “financing” can mean a number of things. When auto dealers advertise that “financing is available,” it means they can give us a car loan. Banks charge financing fees and finance charges for just about everything. Entrepreneurs seek all types of start-up financing to get their businesses up and running.

In this workbook, the term “financing” refers to the process of developing and balancing your financial sources (where money comes from) with uses (what money is spent on).

Depending on what you know about sources and uses, you will want to approach the modules as follows:

Do you know (answer both):		Start with...	Because...
where your money will come from (sources)?	what you would like to spend your money on (uses)?		
Yes	No	Skim the material	Skimming the material is a great way to simply get smarter about financing! However, if you want to complete the exercises, you’ll need to come up with an idea of what you want to spend money on—even if it’s half-baked or for illustrative purposes only.
		<u>Module 5: “What Value Do You Create”</u>	Using the resources in this module can help you identify interventions that can create value for your partnership.
No	Yes	Check out <i>A Typology of Potential Financing Structures for Population Health</i> in Module 3: “Where Can You Find Money for Your Work (And How Do You Get It)?” and start with what will help you address your greatest need; otherwise start with Module 1: “How Do You Move Money Across Sectors and Organizations?” . Then, work your way through all the material.	This workbook was designed to help people who have big dreams, but don’t yet know how to fund them.
No	No	Skim the material	Skimming the material is a great way to simply get smarter about financing! However, if you want to complete the exercises, you’ll need to come up with an idea of what you want to spend money on—even if it’s half-baked or for illustrative purposes only.
Yes	Yes	<u>Module 4: “How Much Will Your Dreams Cost (And How Do You Estimate Those Costs)?”</u>	If you know your sources and uses, the next step is to create a financial plan (if you haven’t already), and this module will help you create one and think through its implementation.



Financing is a practice

Financing is a practice through which you get a sense of where your work is headed and clarity around how you're going to get there—*both in the dollars you'll need and in the actions you'll take*. There are technical elements to any financing practice, such as understanding potential funding sources and developing a financing plan. That said, **the heart of any financing practice is more about the clarity that comes from wrestling with critical questions than it is about numbers in a spreadsheet.**

Financing is a multi-faceted practice.

Financing sits squarely at the intersection of your work on stewardship (how you lead regional transformation efforts) and strategy (what you want to do and why you think it'll be impactful). Oftentimes, multisector partnerships and organizations will wrestle with a challenge they think is related to financing, but once they dig into the details, they find out it's really a stewardship question because it deals with how to get or keep the support of key stakeholders. For example, obtaining the financial support of major regional institutions like hospitals and universities can require the cultivation of relationships with key regional players. Keep an eye out and be open to this integration as you engage with the material in this workbook; you may find there are times when you discover that what your group is wrestling with is not a financing challenge, but something that could be addressed with [stewardship](#)³ or [strategy tools](#)⁴.

Financing happens at the intervention level.

At ReThink Health, we see two primary levels to the work of any multisector partnership or other organization focused on health system transformation. One level involves *strategies*: high-level priorities for action. Examples of strategies might be “encourage healthy lifestyles” or “create more educational opportunities for low-income families.” A second, more specific level is *interventions*. Interventions are any of the primary activities that your partnership engages in to advance a strategy. They are associated with different components of the overall strategy and are the specifics for how you'll implement each component. For example, to “promote healthy lifestyles,” you might encourage kids to walk to school through a Safe Routes to School intervention; and under “create educational opportunities for low-income families,” your intervention might be a scholarship program.

While there are a few exceptions, financing typically happens at the intervention level. In order to get funding, you'll need to get into the details of what you'll be doing, how you'll do it, how much of that work you'll do (scope and scale), and how much you think it'll cost.

Strategy vs. Intervention: A Metaphor

Imagine your friend comes to town and suggests the two of you go out for dinner. She asks you how much money she should bring along. Your response would probably be some version of: “that depends on what kind of dinner you want.” Does she want fast food? Casual? Five-star? Is she hungry or coming off a big, late lunch? In this example, dinner is the strategy. The intervention is what she wants for dinner. In order to tell her how much she'll need, you have to get into the specifics of what she wants.

This workbook will step you through some of the specifics, but—as we highlighted in the *Before You Dive In* section—they'll only be relevant if you already know what you want to finance, even if it's “half-baked” or an audacious dream. This could be a particular intervention or your integrative activities. Make sure you have an idea in mind as you move forward and engage with the rest of the workbook modules.

³ <https://www.rethinkhealth.org/tools/stewardship-guide/>

⁴ <https://www.rethinkhealth.org/resources-list/dynamic-modeling-strategy/>



This workbook will help you find innovative ways to move beyond the grant, but grants are still likely to be a part of the financing puzzle.

Financing is required in the meantime.

You might have some grants that are powering your work, and that's not a bad thing. They can give you space to create and implement some medium- and long-term funding strategies. The good news is, there's work afoot across the country to create dedicated and sustainable financing sources for population health and well-being. The bad news is, it could take a while for them to mature.

In the meantime, you need to start financing your work as sustainably as possible given the current funding landscape. This workbook will help you find innovative ways to move *beyond the grant*, but grants are still likely to be a part of the financing puzzle, and can be especially useful in keeping you and your efforts afloat while you work toward more sustainable financing sources.

A financing practice requires . . . well, practice.

The tools in this workbook are designed to hone your thinking around financing, regardless of your starting point. You don't need answers to every single question, nor do your answers have to be completely thought out. In fact, you might have only rough estimates at first—and that's just fine. Don't worry if you preview the questions and think: "Oh, we don't know that!" Take a guess and see where it leads. Thinking through some of the tough questions with members of your multisector partnership or organization, board members, or other trusted partners will give you insights into more sustainable financing.

How to use this workbook

The material in this workbook is presented around seven key financing questions, which correspond to the module titles. Each module begins with a short introduction to the question that highlights important points—but it's important to note it does not cover every possible element of the question. That introduction is followed by tools to help you answer that module's financing question. You can step through each module in order if you like, or hop around and take up only those pieces that are most important to you.

Within any organization, there are different funding perspectives. For example, you might want to fund your integrative activities, fund a particular intervention, or plan a regional collaboration. You can apply any of the modules to any of your financing questions, no matter the perspective. As we said in the Preface, you just have to be clear about what perspective you've selected.

Our assumption is that you—our beloved reader!—are probably involved in financing your multisector partnership or organization in some capacity. The introductory section of each module gives you the background and context to make the most of each exercise, while the exercises themselves are meant to be completed with others involved in your group's financing. Of course, you can also go through the exercises on your own, but remember: that doesn't mean you're doing this work in isolation. Bring other key stakeholders into this work with you. The earlier they get plugged into the process, the better they will understand the approaches this workbook presents. We think this is exciting material and the most impactful way of engaging with it is with others who see the possibilities!

The Financing Mindset

Have you ever heard the adage that in order to get different results, you have to be prepared to do something different? It's true, particularly in financing. We all walk around with mental models in our heads; they're our shortcuts for how we make sense of the world. These mental models—or mindsets—dictate how we perceive things: what opportunities or stumbling blocks we see, what questions we ask, and how we react. The first step in changing our practices is changing our mindset. Before we dive into the modules in this workbook, it's important to take a minute to reflect on how people tend to approach the work of financing.

Through our work in the field, ReThink Health has observed a dominant mindset that tends to govern the work of financing regional population health efforts. This dominant mindset is shown on the left side of the table below. Exploring the frontiers of financing of population health and well-being, however, requires thinking about financing in new ways and moving to the Financing Mindset, shown on the right side of the table below.

Dominant Mindset	Financing Mindset
Central challenge is acquiring scarce resources for individual interventions	Central challenge is repurposing abundant resources to create new flows of funding for health and well-being
Deference to Status Quo	Proactive Action
Technical	Values-based
Transactional	Systemic
Assembly	Creativity
Task	Journey

So, what is the Financing Mindset? It's the mindset of people and organizations who see the potential resources directed at health as abundant (not scarce) and who seek ways of repurposing resources to create new flows of funding for health. If you want to be a person or an organization with this mindset, you must do the following:



BEYOND THE Grant TIP

There are typically “rules” that dictate who or what gets funding. Being proactive in financing means questioning those rules—and challenging those that are out of date, unfair, or unreasonable. Notice opportunities and ask good questions (asking “why” a number of times often leads someplace interesting) and you will begin to see the system in new ways, uncover new insights, and forge new partnerships—ripe conditions for new funding possibilities.

Take proactive action

See and *seize* your power to act and bring about change. Believe in the value you create—and become masterful at describing it. Recognize that while you probably don't control a whole lot, you do have influence. Use it! Enthusiastically seeking and creating opportunities for action within a system that is often described as complex, uncooperative, and resistant to change is not easy, but sustainable financing depends on it.

See the values behind the numbers

When we hear “financing,” we often think of logic and numbers. While that's true, behind those numbers is a system of values. Quite simply: we finance what matters most to us. A long-serving U.S. Senator once said: “Don't tell me your values. Show me your budget, and *I'll tell you* what you value.” The rules that dictate what gets financed, how, and by whom, are also a reflection of *someone's* values. Behind any flow of money there are a whole host of decisions that established that flow. Seek to understand the values at work in your regional financing flows—whether they are on display in a budget or embedded into a financing process. Strive to ensure those values facilitate the regional health improvements you and others seek.



Think about a system and its component parts

Your work is part of a broad system of health and well-being. While the system and its components are often complex, it can help to think of the components like families (which can also be complex!). There are relationships, connections, intentions, and assumptions that play out in ways we'll never fully appreciate or understand. Unintended consequences often arise as a result of our behaviors. And, often, the links between cause and effect aren't clear. There are perspectives or experiences or time delays that we don't fully understand, and these impede our ability to make the best choices. That same sort of complexity is at work in the health system you operate within. Strive to understand the intricate web of interrelationships at play and engineer solutions that press the right levers, in the right way, at the right time, and you'll deploy your resources efficiently, with the highest returns.

Get creative (don't worry, it's not as scary as it sounds)

Steve Jobs said it best: "Creativity is just connecting things." Connecting diverse experiences. Applying solutions from another sector. Combining pieces from the "old" with the "new." But it's also about taking smart risks. We're often our own worst enemies: not only overestimating the risks but underestimating our ability to deal with them. To be truly creative, think about the work you wish you could do. Don't leave it for someone else to tackle. Also leave room for a little uncertainty. Sure, you might be wrong here and there, but you just might be onto something brilliant.

Commit to the journey

You are in this for the long haul. Creating and maintaining a culture of health in your region is a long-term investment (think 20 years and beyond!) because large-scale change rarely happens in three-to-five years. As with any journey, there will be missteps along the way. To help you manage those bumps, instill a process that incorporates and builds upon the financing mindset; one that enables action, leverages the system, ensures your values guide the work, and encourages creativity at all points along your journey.



We're often our own worst enemies: not only overestimating the risks but underestimating our ability to deal with them.

What are Integrative Activities?

Throughout this workbook, we will be using the term “integrative activities.” We know this is a new term, so we have dedicated this space to explain it.

Integrative activities are roles and leadership functions for governing and managing the work happening within and across multisector partnerships that are working to achieve a common purpose in a region. Those of you using this workbook are likely to have the common purpose of transforming population health and well-being. Your region might have a single multisector partnership with this purpose. Alternatively, you might have many multisector partnerships with distinct purposes (e.g., to improve early education or reduce heart attacks) who come together for the common purpose of transforming regional health.

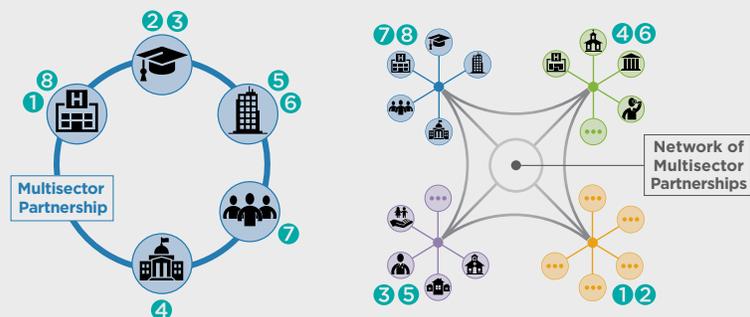
As you know, there are not a lot of resources out there explaining *how* to do this work. Everything designed for you is emergent, and this workbook is no exception. That said, ReThink Health has been teaming up with some regional leaders—people, organizations and partnerships—to better understand the nature of the work, and to develop tools that are most likely to get each of them to their own next level of achievement.

Up until recently, we were part of advancing the idea of a single backbone organization, or integrator, that conducts all the governance and management activities needed to effectively handle collaborative work across organizations; work such as coordinating meetings and communicating across partners. But the more closely we worked with regional leaders and partnerships, the more we understood that’s not how things really work in practice. More typically, *many* leaders and organizations, working together across a region, share responsibility for these integrative activities. Different organizational members of a single partnership, or different multisector partnerships in a network, distribute the roles and regional functions. For this reason, the workbook intentionally does not use the term “backbone” or “integrator.” Instead, we use “integrative activities” to imply that each of the activities could be done by any organization or partnership involved.

Collaborating directly with those engaged in the work, we’ve come across eight categories of integrative activities. The graphic to the right depicts how distributing the activities throughout the partnership or network works, and the chart on page 9 provides more detail about the roles and leadership functions associated with each category of activity.

Since this is a financing workbook, we obviously want to talk about the financing of these integrative activities. [Module 7](#) allows you to explore how some multisector partnerships and organizations working to transform health in their regions have done that. That might surprise you, but it’s true! Some are already getting paid to provide these kinds of services!

When the purpose is to transform health in a region...



...successful efforts ensure eight integrative activities are carried out between stakeholders (in the case of a single multisector partnership) or between all the multisector partnerships in a network.

Eight Integrative Activities

- 1 Convening Stakeholders for Cross-sector Collaboration and Information Sharing
- 2 Analyzing and Planning for Regional Health Improvement
- 3 Designing Ongoing Infrastructure and Governance
- 4 Implementing Strategy; Managing Performance of Region-wide Efforts
- 5 Catalyzing Innovation and Redesign
- 6 Designing Financing Structure and Strategy
- 7 Advocating for Public Policy
- 8 Monitoring, Measuring, and Evaluating Region-wide Efforts

Remember, as you consider what you are doing that you could get paid for, the administration of these activities is part of the cost of conducting those activities. In other words, you should include those costs when figuring out what you should be paid. For example, if you are a leader of a multisector partnership and you supervise someone who designs and executes convenings, then the supervisory time (which is really time spent helping to ensure those convenings are carried out optimally) would be time that you could try to finance as part of that activity. So, if you were to go out and try to get paid for conducting those activities, you would be sure to include the time you spend supervising or administering that work.



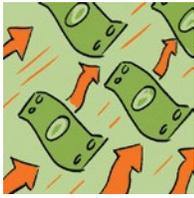
Integrative Activities

Integrative Activities		Specific Roles and Leadership Functions
1	Convening Stakeholders for Cross-sector Collaboration and Information Sharing	<ol style="list-style-type: none"> 1. Engage stakeholders or multisector partnerships 2. Build public will 3. Enroll others in advocacy via convening/organizing 4. Determine agenda 5. Facilitate networking among key leaders 6. Provide communications support, including partnering with conveners to build public will (e.g., website, newsletters, outreach) 7. Manage meeting logistics 8. Create detailed meeting design, including preparation and follow-up
2	Analyzing and Planning for Regional Health Improvement	<ol style="list-style-type: none"> 1. Lead the setting of collective vision and goals; ensure resident involvement in the process 2. Devise shared strategy among stakeholders 3. Identify critical strategic questions, including differences in interests of stakeholders 4. Secure commitments to implement strategy 5. Advocate daily for goals and strategy (internal and external) 6. Facilitate strategy development process, including conducting of needs assessment 7. Serve as a neutral data synthesizer
3	Designing Ongoing Infrastructure and Governance	<ol style="list-style-type: none"> 1. Design and ratify shared governance structure as well as composition and decision-making rules 2. Provide strategic oversight of infrastructure and governance 3. Build relationships with other oversight groups 4. Provide facilitation for interim governance bodies to design governance changes over time 5. Manage recruitment, elections, and transitions in membership of governance bodies 6. Facilitate communications among oversight groups
4	Implementing Strategy; Managing Performance of Region-wide Efforts	<ol style="list-style-type: none"> 1. Strategic oversight of actual implementation; ensure accountability and effectiveness 2. Celebrate successes; share learnings 3. Direct and/or manage projects, which might be about supporting work groups or alignment of activities 4. Support stakeholders' abilities to work within the partnership (e.g., use the partnerships' systems for sharing data)
5	Catalyzing Innovation and Redesign	<ol style="list-style-type: none"> 1. Set audacious goals 2. Lead learning activities 3. Create conditions for innovation 4. Provide seed capital 5. Build human capacity to generate and test innovations 6. Conduct and synthesize research 7. Facilitate networking 8. Manage process of identifying innovations to pursue
6	Designing Financing Structure and Strategy	<ol style="list-style-type: none"> 1. Determine financing vision and strategic priorities 2. Create governance structure for funding decisions and accountability management 3. Determine financing structure for integrative activities 4. Mobilize funding to implement priorities and initiatives 5. Research possible financing structures and provide design support <ol style="list-style-type: none"> a. Develop charitable giving strategy b. Write grants 6. Administer grants, which might include acting as fiscal agent 7. Host innovation fund <ol style="list-style-type: none"> a. Receive and review applications b. Provide recommendations to governance body c. Act as fiscal agent for funds to be redistributed 8. Provide staff support for governance of financing
7	Advocating for Public Policy	<ol style="list-style-type: none"> 1. Set policy priorities 2. Build relationships with thought leaders and policymakers 3. Communicate impact of policies 4. Implement through influence campaigns and more
8	Monitoring, Measuring, and Evaluating Region-wide Efforts	<ol style="list-style-type: none"> 1. Provide strategic guidance and oversight of overall information system 2. Review results and modify action plans 3. Envision and develop process for sharing results with residents 4. Design and facilitate learning and improvement process 5. Monitor progress toward shared goals 6. Design and facilitate forums for accountability to residents

ReThink Health is maintaining a comprehensive list of integrative activities and how multisector partnerships and other organizations are getting paid for conducting them. Please email ThinkWithUs@rethinkhealth.org with any suggested additions. ©2018 The Rippel Foundation.

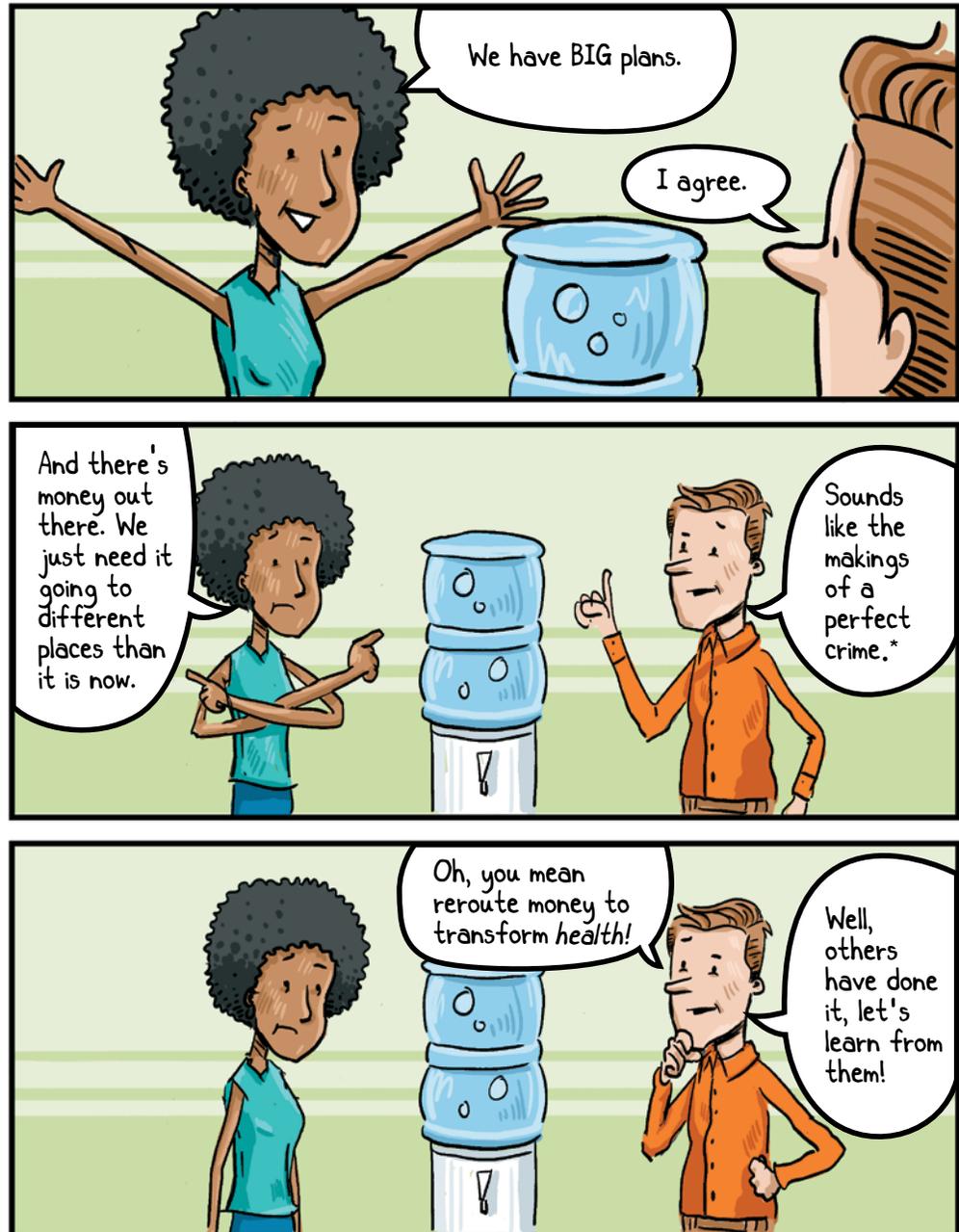


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How Do You Move Money Across Sectors and Organizations?

MODULE 1



*Obviously, this is a joke. ReThink Health does not encourage or condone criminal activity.

Right now, there's a lot of money flowing through your region (trust us: a LOT). If you could capture just a sliver of that, you could make some serious progress. How do you do that? Well, let's start by exploring how others have done it.

How Do You Move Money Across Sectors and Organizations?

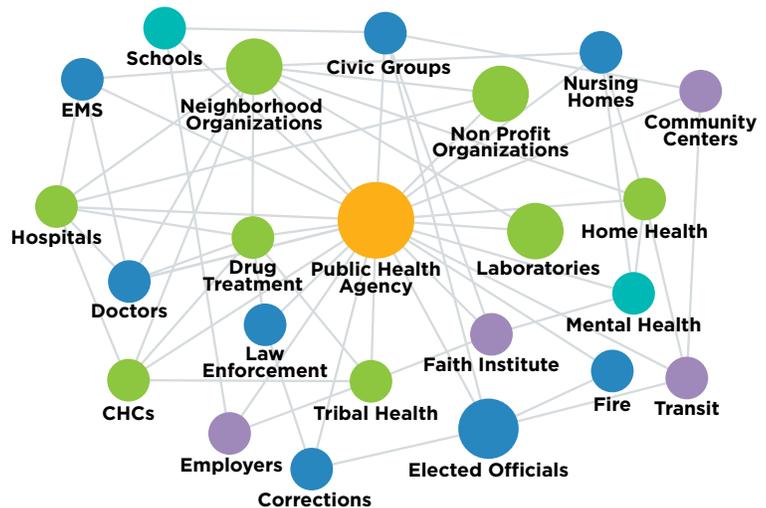
Financial Flows

As a multisector partnership or organization, if you want to transform the system of health in your region, you will need fundamentally different investment patterns—and that requires thinking differently about health and what creates it.

Anything or anyone that impacts the health of your region—for better or worse, in the short- or long-term—is part of your health ecosystem. This includes hospitals, patients, businesses, income assistance programs, and local law enforcement policies, as well as access to fresh food, homeless shelters, and drug treatment centers. Below is a visual representation of a regional health ecosystem¹. As you can see, the health ecosystem is a complex web of interrelated groups from multiple sectors—some that may not, at first, seem related to health. That’s why when we talk about health system transformation, we’re not just talking about health care, we’re really talking about all of the things that impact the broader concepts of health and well-being.

The “Influencing Financial Flows” worksheet on page 3 helps you explore the relationships among your health ecosystem’s components. People and organizations are connected in important ways (see [Module 2](#)), and so, too, are financial flows. You might think of it like a system of pipes, with money flowing between the different nodes. The idea is that, to transform your regional system of health, the pipe system needs to be redesigned—making some pipes larger, adding new pipes, etc. This will redirect the financial flows to maximize the impact on health and well-being. What if, for example, some of the money flowing into criminal justice or corrections flowed into mental health or drug treatment services instead? Or, instead of paying as much for services to deal with urgent problems like addiction, homelessness, or unemployment, what if some of those funds were shifted to upstream investments like education, housing, or transportation that prevent some of those urgent problems in the first place?

The pipes in our metaphor also represent various financing mechanisms, such as social impact bonds, taxes, and contracts. There’s an important distinction to be made here: a financing mechanism moves money, but a financing mechanism is not a source of



“ You might think of it like a system of pipes, with money flowing between the different nodes. The idea is that, to transform your regional system of health, the pipe system needs to be redesigned.

¹ Centers for Disease Control and Prevention. “Public Health System and the 10 Essential Public Health Services.” State, Tribal, Local & Territorial Public Health Professionals Gateway. September 20, 2017. <https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html>.



money (see [Module 3](#)). A mechanism moves money from one place to another (the pipes), but it needs a source behind it (a reservoir, river, etc.). Installing a great pipe system in your home wouldn't do much good if it wasn't hooked up to a water source!

In your work, you are most likely going to have to move money via some sort of financial mechanism. And that mechanism will need a source behind it.

So how do you redesign the pipes to get the money where you want it to go? Anyone who has done it before will tell you there are no easy answers to this question. There are, however, conditions that enable the successful movement of money across sectors and organizations, and unpacking those conditions for your own region is a great first step. So, let's do that! Take a few minutes and think of an example from your region of a time when money was successfully moved from one place to another—or “reallocated”—within your health ecosystem.

Examples might include:

- A tax, like a sugar-sweetened beverages or public health tax
- A private-sector activity, such as [Kaiser Permanente's mission-driven alignment efforts](#)² (e.g., buying local, working with woman- or minority-owned firms, and selecting green energy)
- A legislative allocation that created a funding source or a health-related entity

Along with those typical examples, it's often overlooked that, in many cases, the money to fix a problem is already in the ecosystem, but is being directed in a less impactful way. As we mentioned earlier, funds currently being used for expensive treatments for urgent problems could be redirected upstream toward interventions that prevent those emergencies in the first place—often without requiring government policy changes. For example, one multisector partnership set up a program that sends professionals to visit low-income people living with diabetes to help them manage their health condition. This effort produced cost savings because it prevented numerous expensive emergency room visits for those patients. And, unlike the urgent treatment of symptoms, the intervention helped address the long-term problem, leading to even more potential savings down the road (not to mention better health outcomes for the patients).

Once you have an example of a successful financial reallocation in mind, step through the “Influencing Financial Flows” worksheet on page 3. If you don't know the answers, schedule coffee or a meeting with someone who does. (Bring a colleague or someone from your multisector partnership or organization along!) As you discuss the questions, keep in mind the difference between a mechanism and a source. The last question on the worksheet asks you to apply any insights you gleaned to an upcoming challenge or question you are facing. Answering this will help you take what you learn from the success story and apply it to your work.

“ There's an important distinction to be made here: a financing mechanism moves money, but a financing mechanism is not a source of money.

² <https://stakeholderhealth.org/tyler-norris/>



MODULE 1

WORKSHEET

Influencing Financial Flows



OBJECTIVE: Identify the conditions that support the ability to move money across sectors or organizations in your region so you can think more comprehensively about how to influence financial flows.

TIME: Approximately 45 minutes

MATERIALS: One copy of this worksheet (for leading the exercise)

PARTICIPANTS: A few members of your multisector partnership or organization, or other trusted colleagues.

To Begin

Think of an initiative—from your multisector partnership or otherwise—that successfully redirected money to support health transformation in your region. This could be a new tax, new funding for a public health intervention, membership fees to support the integrative activities your organization handles, etc. Agree on what initiative you'd like to discuss as a group.



As you work through these questions, it's likely you'll discover a tension between control and influence. While you probably don't control the flow of money through your region, you do have influence. Think about how you can best leverage that influence.

1. Who initially produced this funding? When this proposal was made was there any pushback and, if so, why? Were there any surprises in how it was received? If so, what was their nature?



2. What key steps did it take to gain traction and move the proposal forward? Were there extraordinary efforts and/or a certain amount of courage required? If so, what was its nature?

3. To what extent did getting support for the proposal require each of the following?

Conditions That Could Impact Willingness to Move Money	1 = none/not at all required 5 = extensively required
Willingness to take risks	
Problem solving	
Securing champions/political support	
Determination to persevere through challenges and setbacks	
Unity of key stakeholders	
Relationship building	
Financing expertise	
Focus on the long term over the short term	
Building a shared understanding of the problem	
Building confidence in population health and multisector partnerships as frameworks for change	
Other (please list)	

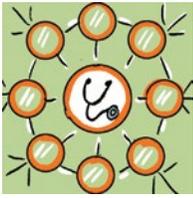


4. How long, approximately, did the initiative take to accomplish from idea to implementation? What factors influenced the length of time?

5. Under what conditions would you recommend it be done again?

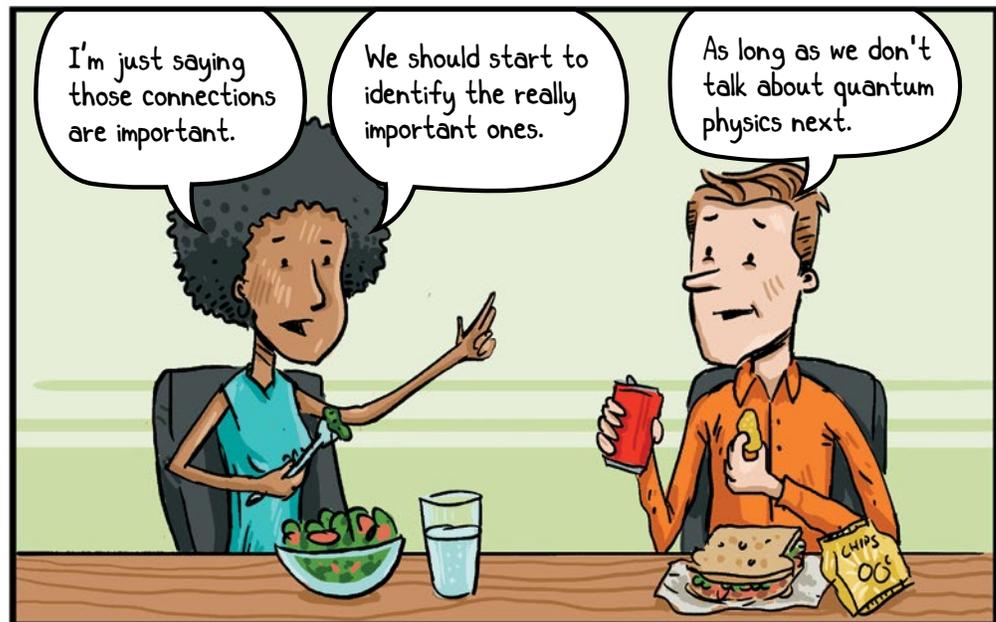
6. What insights did this worksheet reveal that you could apply to one of your financing challenges?

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What Is A System (And How Does It Influence Who Wins and Loses)?

MODULE 2



Systems, systems thinking, systems-oriented . . . enough already! What the heck is a system anyway? Find out how understanding it can help your partnership or organization achieve its goals.

What Is a System (And How Does It Influence Who Wins and Loses)?

In this workbook, we often refer to systems. But what does “system” really mean?

A system at its most basic level is a set of interacting or interrelated parts with a specific purpose. We are all a part of a number of different systems. Our families, faith-based groups, and the organizations we work and volunteer for are all systems. Our bodies have systems. Our communities have numerous systems, such as the criminal justice system and educational system.

In health, talking about *systems* is particularly tricky because many people, when they say “health systems,” are actually referring to health *delivery* systems, which are comprised of hospitals, providers, and sometimes payers. In this workbook, you can be sure any reference to a *system* refers to the *health ecosystem*. Remember, health is a function of numerous conditions: employment, education, housing, neighborhoods, and social connections to name a few. All of these variables—and the interrelated stakeholders, multisector partnerships, and organizations associated with them—make up your region’s health ecosystem.

Why does a system matter?

The answer, simply put: impact.

Have you ever tried something—an intervention or other action—only to have it play out in ways you didn’t anticipate? (“I didn’t think that would happen!”) That’s actually a well-known systems phenomenon called “fixes that fail.” These sorts of failures can be avoided, but they happen when your solution doesn’t consider the whole system and all of its interacting parts.

Think of a system like a set of gears. Each gear represents a separate stakeholder in your system. As your work enters the system, some of the gears might be able to keep turning as they normally do, but your work might impair another gear—causing a backup, damaging the gear in some way, or even bringing part of the system to a complete stop. By exploring the connections, relationships, and motivations in your system, you can better understand how your work impacts the gears—or stakeholders—in positive and negative ways and how to design your work to address those impacts. This is an important early step to transformational change.



Think of a system like a set of gears.





Gaining insight

Studying systems—often called “systems thinking” or “systems dynamics”—can get highly complex and technical. There are, however, some simple ways to dip your toe into the system waters and begin to gain awareness of and explore the system you want to transform. This module will guide you through two exercises, each giving you a different kind of systemic insight.

The first worksheet, “Exploring Your System,” on pages 5-7 helps you identify key stakeholders in your system and think very generally about the impact those connections have on your work and theirs.

The second worksheet, “Considering Costs and Benefits,” on pages 9-12 asks you to consider a specific intervention and guides you through a process to understand how that particular intervention impacts stakeholders in your system—both positively and negatively.

These worksheets are best done with a group of people who represent the key players in your system. You might convene a handful of stakeholders and walk through the worksheets as a group, or you might just work with your own staff or board. *The more people participating in the completion of these worksheets, the more insightful the results will be.* Whoever you assemble, however, keep in mind that the work doesn’t have to be perfect. Just give it a go, view the results as a work-in-progress, and revisit them occasionally or share the results with different stakeholders and get their feedback.

What to Expect from the “Exploring Your System” Worksheet

The first step in understanding your system is simply identifying stakeholder connections, and the “Exploring Your System” worksheet steps you through a process to do that. Identifying the connections allows you to understand a number of important variables, including: (1) which stakeholders are a part of your system, (2) how the work of the various stakeholders ripples out across the system, and (3) how money flows between stakeholders.

The discussion questions at the end of the worksheet help you analyze your diagram. Pay particular attention to Question 4, which asks you to consider financial linkages. These can be harder to identify, but it is almost certain that your partnership’s financial well-being is connected in very meaningful ways to other stakeholders in the system, be they funders, insurers, providers, or others.

[Click here](#) to jump to the “Exploring Your System” worksheet (digital version) or turn to page 4 (print version).

“ It is almost certain that your partnership’s financial well-being is connected in very meaningful ways to other stakeholders in the system.

What to Expect from the “Considering Costs and Benefits” Worksheet

Change can be hard because it’s often not a win-win proposition: some will “win,” others will “lose.” Sometimes those impacts are clear; other times there are unintended or overlooked consequences. Understanding your system can help you sort through potential impacts.

The “Considering Costs and Benefits” worksheet will help you apply that logic to a specific intervention you have in mind. You could do this exercise for any part of your work that has any kind of impact, such as a capital project or your integrative activities, but for simplicity’s sake these directions will focus on an intervention.

When trying to create change within your system, it is important to collaborate with many system stakeholders to think through—at that detailed intervention level—how the change is likely to impact them (including stakeholders who might not be a part of your conversations and decision-making). Often, this means sorting

through elements of stakeholders' interests by asking questions such as: What issues and outcomes do they care about? How do they deliver their services? How do they make money or generate a profit? How will the proposed change show up in their work? How will their work show up in the proposed change?

Analyzing the impacts at the intervention level also helps you spot opportunities and potential partners because you can see where interests align and where conflict lurks. In the sugary drinks tax example, there will be tax revenue. How might that revenue be divvied up to mitigate any negative impacts? Who might gain from how the money is spent?

While fully exploring those interests—and norms and barriers to change—takes time, you can identify the elements that are most pressing to your work. The “Considering Costs and Benefits” worksheet will walk you through a process of analyzing the impact your interventions have on key stakeholders—i.e., the degree to which each “wins” or “loses” in a given intervention.

Two important considerations in this worksheet:

1. As you think about stakeholders, **pay attention to time horizon.** Sometimes the winners and losers can change over time. One party might appear to get the short end of the stick in the short run, but as time goes by they might see overall benefits. For example, bars and restaurants often lose revenue immediately after a smoke-free ordinance takes effect, but studies have shown that—over the long-term—their customers and revenue will increase.
2. **Pay attention to perception versus reality.** When possible, study actual effects by looking at other regions that engaged in similar activities or exploring data. Many times, people will offer up what they perceive to be the positive or negative impacts. Constructive conversations can help separate reality from perception.

The insights gained from completing this worksheet will allow you to optimize the design of your intervention, and open up new possibilities and questions to explore with key stakeholders. A well-designed intervention will ultimately yield better results and greater impact.

[Click here](#) to jump to the “Considering Costs and Benefits” worksheet (digital version) or turn to page 7 (print version).



**BEYOND
THE Grant TIP**

Imagine you're planning to advocate for a sugar-sweetened beverage tax in your region and, in the planning stage, you see that local retailers might be negatively impacted by a decrease in their sales of sugary drinks. Since you are in the planning phase, you have options. For one, you can invite the local retailers to the table to explore how best to alleviate the negative impacts—perhaps, for example, you could plan for the tax to be phased in or you could develop materials to help retailers explain the tax to their customers.



WORKSHEET

Exploring Your System

MODULE 2



OBJECTIVE: To understand what a health ecosystem is and how stakeholders in that system impact one another, including financial connections.

TIME: 20-30 minutes (or more if you'd like)

MATERIALS:

- One copy of this worksheet (for leading the discussion)
- Flip chart or white board
- Markers

PARTICIPANTS: *The more stakeholders that participate in this worksheet, the more insightful your diagram will be, so assemble as many members of your multisector partnership or organizational stakeholders as possible; try to get a good sampling of perspectives/sectors.*

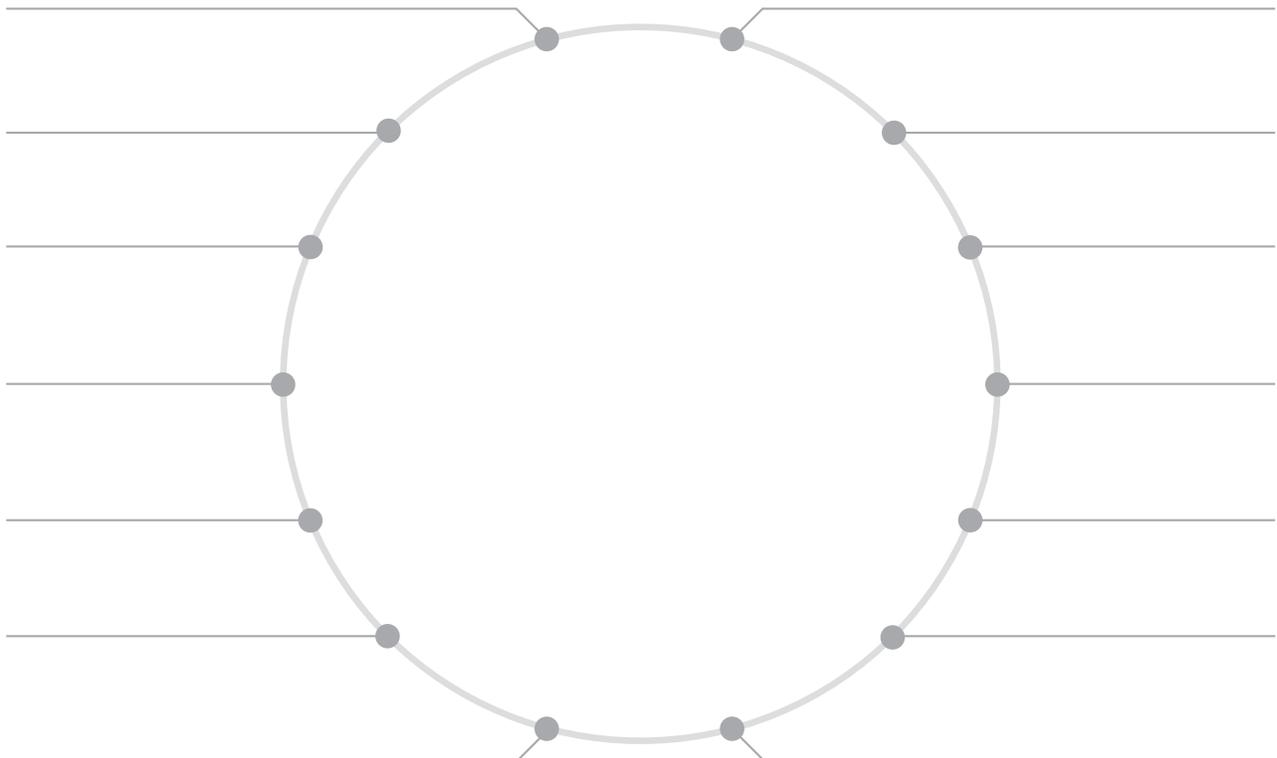
A note before starting

While you've been asked to think about a specific intervention as you step through this workbook, for this worksheet you should think generally about all of the activities in which your partnership or organization is engaged. You need to think broadly in this exercise, and getting too specific in this worksheet will actually limit your ability to do that.

STEP 1

On a white board or flip chart paper, draw a large circle, as shown in Figure 1. Ask each participant to write the name of their organization on the periphery.

Figure 1.

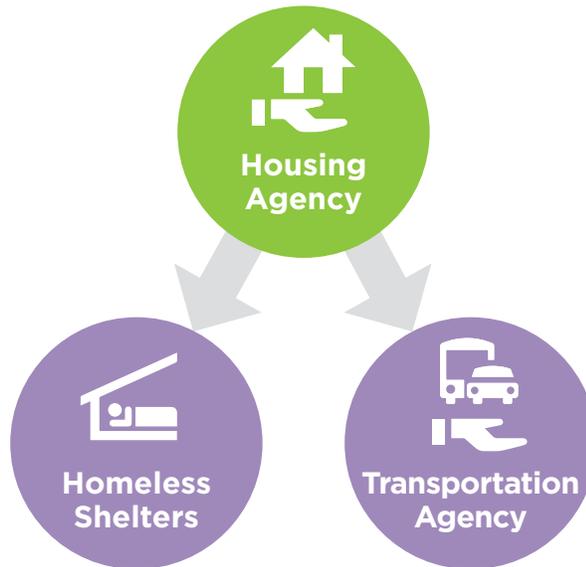


STEP 2

Ask each stakeholder to identify two other organizations represented on the circle whose decisions impact their work. (Examples: a lack of chemical dependency treatment in prison means more emergency department visits for my hospital, the local government's underinvestment in public transportation means less preventive care provided in local clinics, etc.).

On the circle, ask each stakeholder to draw a line between themselves and the other two organizations they identified.

FOR EXAMPLE



STEP 3

Once everyone has completed Step 2, go around the table again, but reverse the direction of the impact by asking each stakeholder to identify two organizations whose work is impacted by that stakeholder.

Ask each stakeholder to draw a line across the circle between themselves and the other two organizations they identified.

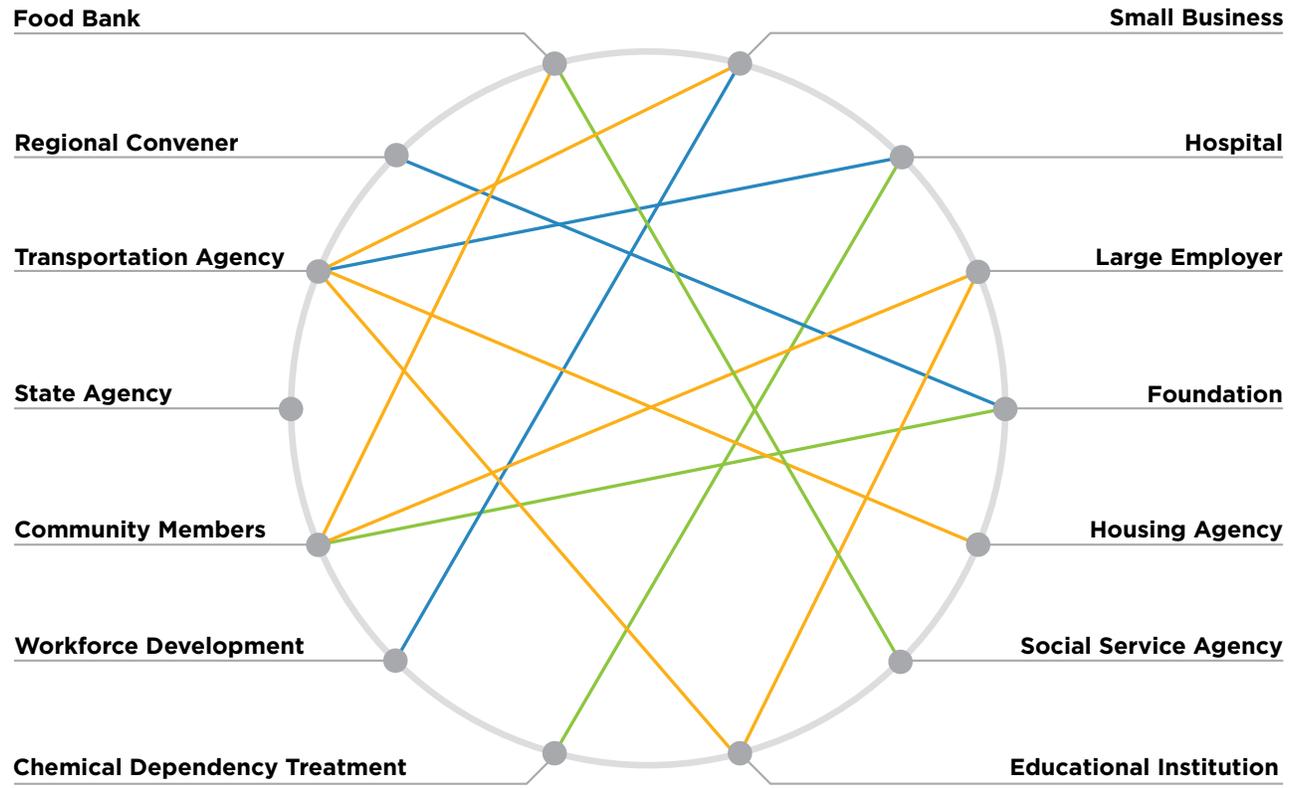
FOR EXAMPLE





Figure 2 below is an example of how your diagram may look after you finish this step. (The names provided are just examples; your diagram should have the names of specific organizations when possible.)

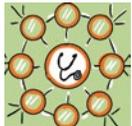
Figure 2.



STEP 4

As a group, look at the resulting diagram and discuss the following questions:

1. What sort of picture emerges? Do some organizations have more connections than others? If so, why is that? Are there any surprises?
2. Beyond the four connections (two in each direction) each participant already provided, what other critical connections may be missing?
3. Does the diagram suggest any important areas for alignment of interests? If so, what are those areas?
4. How are the identified organizations linked financially? What are the implications of those linkages? (For example, perhaps a multisector partnership improves the health of the community and reduces admissions to a local hospital. This would be an important financial connection.)



WORKSHEET

Considering Costs and Benefits

OBJECTIVE: To understand the impact specific interventions will have on other stakeholders within the system.

TIME: 60-90 minutes.

MATERIALS:

- Poker chips or similar tokens in two different colors (preferably red and blue), ten chips of each color for each participant
- Printed version of Sheets 1 and 2 on tabloid (11" x 17") paper

PARTICIPANTS: A group of people who represent the key players in your system. You might convene a handful of stakeholders and walk through the worksheets as a group, or you might just work with your own staff or board. The more people participating in the completion of these worksheets, the more insightful the results will be.

STEP 1

Give each member of your group 20 chips—10 red, 10 blue.

STEP 2

Ask the group to identify an intervention to explore for this exercise. This can be work your multisector partnership or organization is considering, or is in the early stages of planning. Write the intervention's name and/or a short project description in the space provided at the top of Sheet 1. We use the example of an intervention here, but you could use this exercise to consider the costs and benefits of any other aspect of your work.

STEP 3

Across the top of Sheet 1, in columns C-J, list up to eight stakeholders who will be impacted by this intervention. (Stakeholder 1, Stakeholder 2, etc.). These stakeholders can be active partners, but they can also be external stakeholders.

STEP 4

Together, make a list of the intervention's benefits. These do not have to be actual monetary benefits (e.g., increasing your partnership's public profile). Write those benefits in Column A.

STEP 5

Have each group member allocate their 10 blue chips to each benefit by placing them in Column B, according to how impactful they believe each benefit to be. There's no rule regarding how group members should allocate their chips—they can be spread across several boxes or placed all in one. Discuss as a group whether this allocation, as represented by the total chips in the various boxes, seems reasonable. Discuss and make any changes if you'd like. Reach consensus on a final allocation.



Pay attention to perception versus reality. When possible, study actual effects by exploring data and looking at other regions engaged in similar activities.



STEP 6

Once all of the chips are in Column B, discuss as a group how to allocate them across each corresponding row among the stakeholders.

For example, if group members have placed 15 blue chips in total on a benefit called “increased profile for partnership,” decide as a group the extent to which the various stakeholders are impacted by this benefit and allocate the 15 chips accordingly. Again, chips can be allocated to one stakeholder or spread across any number of them.

STEP 7

Now turn your attention to Sheet 2. Identify any burdens, costs, or negative consequences and list them in Column A.

STEP 8

Repeat Step 5, this time allocating the 10 red chips in Column B among the costs you just listed.

STEP 9

On the bottom of Sheet 1, enter the total benefits for each stakeholder in the Totals row. Then, go to Sheet 2 and enter the total costs for each stakeholder in the Totals row there. Now copy the totals from Sheet 1 into the Sheet 1 Totals row on Sheet 2. Finally, subtract the Sheet 2 totals from the Sheet 1 totals to fill in the Net Benefits/Costs row on Sheet 2.

Look over the outcomes, as shown in the Net Benefits/Costs row. As a group, discuss:

- Who are the big winners? Losers?
- Is the outcome what you expected?
- Is there an outcome you'd prefer?
- What, if anything, could move you closer to your preferred outcome?

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Table 1: Benefits

COLUMN A Benefits/Positive Consequences (+)	COLUMN B Total Allocation	Columns C-J: Stakeholders							
		Stakeholder 1	Stakeholder 2	Stakeholder 3	Stakeholder 4	Stakeholder 5	Stakeholder 6	Stakeholder 7	Stakeholder 8
1									
2									
3									
4									
5									
Total									



Initiative Name:

Short Description:

Print on Tabloid (11x17) Paper.

Table 2: Costs

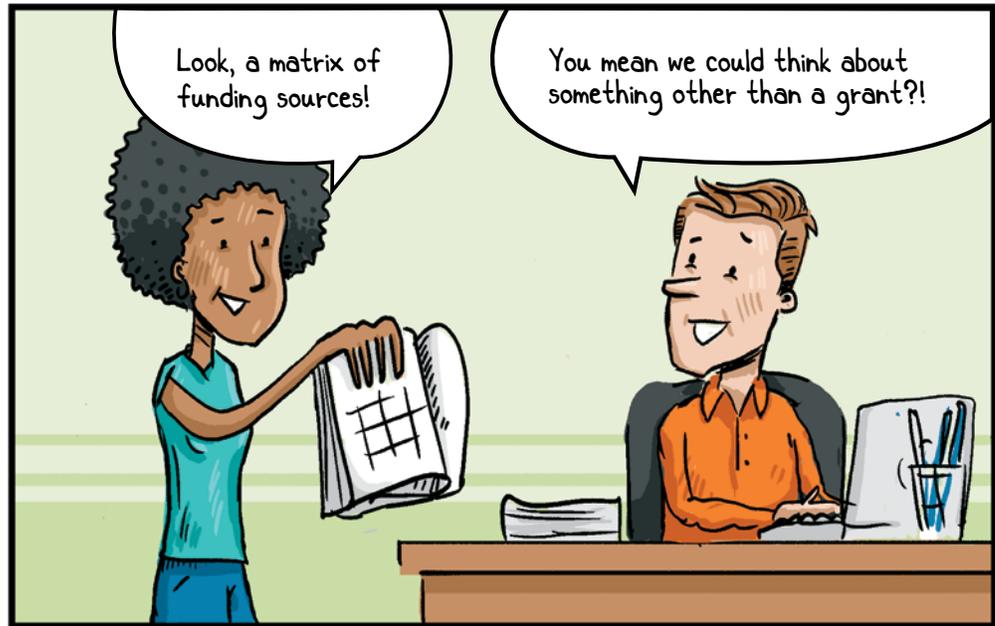
COLUMN A Costs/Negative Consequences (-)	COLUMN B Total Allocation	Columns C-J: Stakeholders							
		Stakeholder 1	Stakeholder 2	Stakeholder 3	Stakeholder 4	Stakeholder 5	Stakeholder 6	Stakeholder 7	Stakeholder 8
1									
2									
3									
4									
5									
Totals									
Sheet 1 Totals									
Net Benefits/Burdens (benefits minus burdens)									

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Where Can You Find Money for Your Work (And How Do You Get It)?

MODULE 3



Got grants? Great! Now let's talk about some other funding sources and see which ones are right for your partnership or organization!



Where Can You Find Money for Your Work (And How Do You Get It)?

Financing Structures

When talking to folks like you—members of multisector partnerships or organizations—one of the most common questions we hear when it comes to sustainable financing is: “What are the innovative financing mechanisms?” Leaders want to know, for example, about social impact bonds, blending and braiding, and wellness funds.

What do these financing mechanisms have in common?

Answer: as described in [Module 1](#), they are mechanisms, *not sources of funding*. The money does not actually come *from* the mechanism itself. Instead, financing mechanisms are transactional; they are techniques or instruments you can use to pool, distribute, and/or transfer funds. A mortgage is a financing mechanism. A credit card is a financing mechanism. But you need to have some money in the bank when you use them. For example, the sources of money used to repay the credit card might be income from your job or an inheritance—i.e., funding *sources*. So it is unlikely that a focus on mechanisms will end your quest to understand where to find money for population health interventions.

Let’s face it. There are no easy, readily accessible sources of sustainable funding. There are no magic shortcuts. But there are a variety of innovative options being used across the country. And there is a way of thinking about these options that can help point you in the right direction. We have summarized these options in *A Typology of Potential Financing Structures for Population Health* shown on page 6.

The *Typology* recognizes two critical aspects of funding options:

1. where the money comes from (sources); and
2. the process by which the money is acquired and/or allocated for the desired purpose (which may or may not involve financing mechanisms).

Together these constitute what we’re calling a **financing structure**.



The word “structure” may sound like a catch-all term, but it is appropriate here because it suggests an arrangement, composition, or system of decisions, protocols, procedures, and authorities. In short, there is much more to consider than simply the funding source.

Take a look at the *Typology*, and you’ll see that each financing structure has a particular set of decision makers, a particular process for making decisions, and particular constraints. That is, each structure involves a different set of relationships, skills, and conditions to obtain funding. It’s a lot to keep in your head—no wonder most multisector partnerships rely on grants!



Let’s face it. There are no easy, readily accessible sources of sustainable funding. There are no magic shortcuts. But there are a variety of innovative options being used across the country.



The Typology

Let's do a quick walk through of the *Typology*. In the two left-hand columns, the financing structures are sorted by their sustainability.

- **Grants** are a great source for one-time needs, like short-term projects or gap funding for a construction project. They can also be used for seed money to start a long-term project, but you must find more sustainable funding sources eventually. Grants can also provide a sort of “bridge funding” to keep you going temporarily while you pursue more sustainable funding opportunities.
- Various types of **loans, bonds, and equity investments** can finance capital projects or provide working capital or start-up funding. However, the critical aspect of all these sources is that you must pay the money back; moreover, investors usually (but not always) expect a financial return on their investments.
- New **health care payment models based on value** can provide funding for non-clinical services, such as The Diabetes Prevention Program or community health workers.
- **Reinvestment** is the practice of taking excess revenue (i.e., revenue that exceeds expenses) and placing it back into the same enterprise and/or the same purpose. Generally speaking, to make reinvestment work, you must have protocols for measuring and accounting for savings, means to turn avoided costs into spendable cash, and agreements that distribute the funds. Without standardized models for reinvestment, the political and technical lift to put an agreement in place can be quite heavy.
- **Public revenues** include dedicated taxes, tax expenditures (i.e., tax breaks), and fees. These revenue sources differ from general taxes, like property taxes and income taxes, which are collected and distributed through a public appropriations (or budgeting) process (see next bullet) because they are levied for specific purposes.
- **Public appropriations** are spending by government agencies for services, goods, or grants (funds are also appropriated to repay bonds). This category of funding sources is especially important for two reasons. First, the primary funding source for social determinants of health—e.g., affordable housing, public safety, clean environment—has traditionally been the public sector. Second, the combined mix of that spending (a public jurisdiction’s “portfolio”) is of critical importance to population health outcomes.
- **Institutional purchasing and investing** comprises the set of decisions institutions make about their own business that can help—or hurt—the social determinants of health. Do they buy local? Are they environmental stewards? Do they create healthy workplaces? While this applies to any institution in a community, such decisions are particularly significant for “anchor organizations” because of their large size and impact on the local economy as well as social and environmental conditions.
- **Mandates** are simply government policies—federal, state, or local—requiring that specific purposes be funded. The notorious “unfunded mandate,” provides no funding but nonetheless is quite powerful because it forces the provision of financial resources for a specific purpose. The Americans With Disabilities Act is a great example of just how powerful a mandate can be.
- **Earned income** is money generated from paid work. A multisector partnership or organization may offer services or products that others want to purchase, such as serving as a fiscal agent (i.e., performing financial duties on another organization’s behalf), or preparing a community needs assessment.

Want to learn more about financing structures? Check out [Appendix 3](#).

“ While more than one revenue source might be available to fund your intervention or integrative activities, it would be a mistake to view the sources as interchangeable.



The *Typology* Can Help You Think About Each Structure

At first glance, the list of financing structures might sound like a rather odd assortment. For example, why are public revenues (such as taxes or tax credits) separate from public appropriations? How is a mandate a financing structure? These questions get to the heart of what the *Typology* is all about. It demonstrates to multisector partnerships and other organizations seeking funding that a great idea is only the *beginning* of the process.

While more than one revenue source might be available to fund your intervention or *integrative activities*, it would be a mistake to view the sources as interchangeable. Each is shaped by its industry, as well as by institutional goals and business models, norms, practices, protocols, interests, and expectations around accountability for the use of the funds. The “Who Decides on Availability and Conditions,” “Decision Making Process,” and “Primary Influences on Supply” columns of the *Typology* begin to distinguish some of these differences. They’ll help you understand who makes decisions—and by what process—as well as what factors influencing the supply of the funding source. The “Why Important” and “Key Challenges” columns point to benefits and impediments to each financing structure, further illustrating their differences.

As examples, let’s look at how some financing structures differ in their level of public involvement. Tax policy typically has a very public-facing process. Dedicated taxes, such as Philadelphia’s sugar-sweetened beverages tax, often involve a large public campaign—either to influence a public referendum or a legislative vote. These campaigns build up public expectations around the use of the funds. By contrast, public appropriations are steeped in a mostly inward-facing budgetary process composed of administrative and legislative procedures, lobbying by special interests, and esoteric spending rules such as those concerning entitlements, balanced budget requirements, and fiscal notes.

When you know there is so much more to it, you can see how simply asking “What are the innovative financing mechanisms?” might lead you down the wrong path. It is perhaps more useful to ask, “What relationships, skills, and conditions are our strong suit?” This approach allows you to start cultivating funding sources through your strengths, rather than stretching your capacities. The “Exploring Your System” worksheet on page 4 can help you prioritize possible financing structures by considering how well various structures match up with your existing skills and assets—recognizing that, along the way, you’ll build stronger and broader relationships, more financing expertise, and a keener eye for assessing and adapting to prevailing conditions. Over time, you will build the skills and relationships necessary to pursue additional sources.

A note about financing structures for your integrative activities

The *Typology* can help you think through possible funding sources for your integrative activities. There are two ways to fund those activities: directly or indirectly. You could use one or both approaches.

Two Approaches to Funding Integrative Activities	
DIRECT	INDIRECT
Revenue is allocated directly to integrative activities; direct revenue is used to fund <i>only</i> integrative activities (it does not also offset or pay for an intervention, etc.).	Revenue is allocated as part of a larger initiative in recognition of the value of the integrative activity to the overall effort. This is sometimes referred to as an administrative or overhead charge. This type of arrangement is typically stipulated in a funding agreement between your partnership or organization and the funder.
Example: Membership fees or grants which only finance integrative activities	Example: As part of an \$800,000 public appropriation, \$64,000 (8%) is allocated to offset the costs of integrative activities



WORKSHEET

Exploring Financing Structures



OBJECTIVE: Begin to explore and prioritize the financing structure(s) that best fit the capabilities and needs of your partnership or organization.

TIME: Approximately 45 minutes

MATERIALS:

- Printed copy of *A Typology of Potential Financing Structures for Population Health* (print on tabloid 11x17 paper)
- One copy of this worksheet (you might need multiple copies of pages 7 and 8)
- Whiteboard or flip charts (optional)
- Markers (optional)

PARTICIPANTS: Two-to-ten members of your multisector partnership or organization, ideally from the leadership team. If you have more than six people, divide into relatively equal groups to do the exercise.

A Typology of Potential Financing Structures for Population Health recognizes two critical aspects of funding options:

1. where the money comes from (sources); and
2. the process by which the money is acquired.

Combinations of these constitute what we are calling a **financing structure**.



This exercise will help you explore and evaluate various financing structures by considering them in light of one of your interventions or integrative activities (remember, interventions are any of the primary activities that your partnership engages in to advance a strategy, and integrative activities are roles and leadership functions for governing and managing the work happening within and across your partnership). Keep in mind that this worksheet is not meant to be prescriptive for what type of financing structure is best for your current work, but a way to explore the various financing structures and the conditions in which they function.

STEP 1

As a group, agree on an answer to the following question: for purposes of this worksheet, what is one intervention or integrative activity you would like to fund in the next 12-24 months?

This can be anything you are interested in or currently working on. It might be a policy or program, your integrative activities, or it could be something more encompassing, such as a Wellness Fund. Write your agreed upon intervention/activity on a flip chart or whiteboard.

STEP 2

With that intervention/activity in mind, look through the *Typology*. Examine the various financing structures and the conditions in which they function. Select up to three financing structures to explore.

STEP 3

Work through the “Evaluating Possible Financing Structures” exercise on pages 7 and 8 for each financing structure chosen in Step 2. If you have more than one group, include a report out period of up to 15 minutes so the groups can share the results of their deliberations.

STEP 4

For discussion purposes, agree on the single financing structure that seems to be the most viable option to fund the intervention/activity from Step 1. After you pick one structure, discuss the questions below as a group (combine your groups if you have more than one). You may find it helpful to record the group's answers on a whiteboard or flip chart.

- What conditions are necessary for this financing structure to work in your region (e.g., you would need the business community to champion a new tax)?
- What additional information would you need to decide whether or not to greenlight the pursuit of this financing structure? What specific steps could you take to:
 1. acquire this information; and
 2. move toward an actual decision?

Still feeling stuck or discouraged?

Dig into the examples in the *Typology* to learn more about how these financing structures are working within real institutions. Remember that this worksheet's purpose is to help you explore various financing structures; it is not prescriptive. Your group can step through the worksheet a number of times with different interventions or activities in mind, to consider a number of financing possibilities.

If, while engaging with the *Typology*, you realize that grants are the only viable option for you now, don't be discouraged. Consider adding financing expertise to your partnership by hiring a new staff member or consultant, recruiting an additional board member(s), or forming an alliance or partnership with an organization, etc. Also, keep in mind that you don't have to pick one structure and stick with it indefinitely. Experience with one structure can lead to other possibilities or add to your skills and capabilities in a way that enables you to pursue other structures.

Finally, try going through [Module 1, "How Do You Move the Money Across Sectors and Organizations?"](#) to think through the conditions that enable moving money across sectors or organizations in the region.





What does it take to access these structures?
Which structures have the greatest potential, and in what circumstances?

Print on Tabloid (11x17) Paper.

	Financing Structure	Description	Examples/Mechanisms	Who Decides on Availability and Conditions	Most Suitable Applications	Decision Making Process	Level	Primary Influences on Supply	Why Important	Key Challenges
Temporary or One-Time Funding	Grants	Arrangements that provide funding for specific initiatives and do not need to be repaid	CMS Innovation grants (Medicaid Incentives for the Prevention of Chronic Diseases Model), foundation grants, hospital community benefit grants, prizes or competitions (Aspire Challenge), gap funding for capital projects, and loan loss reserve funds	Foundations*, government agencies, hospitals	Up-front costs, such as development or planning costs, one-time projects or costs	Grantors' internal grant-making policies and practices	Federal, State, Local	Legal requirements for foundations and community benefits, appropriations for government, corporate policy	Can spur innovation by providing funds to items considered too risky for other funders, can leverage other funds	Short-term, grant terms not always consistent with grantees' core work
Funding That Needs To Be Repaid	Bonds	Debt issued as bonds. Investors purchase bonds with expectation they will be repaid over a specified time period at a specified interest rate	General obligation bonds, transportation revenue bonds, sewer bonds, housing revenue bonds, hospital revenue bonds, San Francisco's affordable housing GO bonds	Typically issued by a government/public authority or quasi-public/private authority (e.g., a development finance agency)	Projects with long-term revenue sources (e.g., rental payments, user fees, health care fees) because debt must be repaid	Highly standardized and institutionalized investment protocols	State, Local	Investors' appetites, government willingness to issue, government debt policies, sufficiency of revenues for repayment	Provides capital for interventions in which revenue streams accrue over many years	There must be a revenue source to repay funds. Bonds are rated for risk; the higher the risk, the greater the interest rate
	Loans	Through loan agreements, investors fund specific initiatives expecting to be repaid over a specified time period at a specified rate of return	Program-related and mission-related investments (PRIs/MRIs) made by private foundations (Community Memorial Foundation , Kresge Foundation), community development financial institution (CDFI) loans (Community Loan Fund , Equity With a Twist)	Institutions making the loans—typically foundations, government agencies, or CDFIs	Projects with long-term revenue sources (e.g., rental payments, user fees, health care fees) because debt must be repaid	Contractual loan agreements, which may vary by funder	State, Local	Investor appetites, creditworthiness of investment, sufficiency of revenues for repayment	Provides capital for interventions in which revenue streams accrue over many years	There must be a source to repay funds. Contractual terms can differ from funder to funder
	Pay-for-Success	Investors fund specific interventions with expectations that the intervention will meet performance specifications, upon which repayment is contingent	Social impact bonds (Goldman Sachs' Chicago early education program), performance contracts (Strong Families Fund), human capital bonds (Pay for Performance Act MN), SIPPRA (the Social Impact Partnerships to Pay for Results Act)	Sponsoring agencies: the nonprofit or government agencies willing to pledge future revenue streams	Projects with 1) a clear ROI—probably a financial ROI, 2) partners willing to channel future budget streams into performance payments, 3) partners willing to forego highly sophisticated measures of success	Negotiated contracts	All governmental levels, as well as private sector	Requires an entity willing to provide upfront capital and take financial risk	Promotes and demonstrates the value of population health interventions, source of financing when there's reluctance or inability to invest through a direct appropriation	Complex, expert transactions that can be time-consuming and very costly to arrange, including measurement and evaluative requirements
	Equity Investments	Investors purchase ownership shares in an enterprise expecting the business's earnings and/or assets to grow. Returns accrue to the investor when the ownership share is sold	Venture capital, corporate investing (Healthy Neighborhoods Equity Fund), Opportunity Zones , Dallas Children's Health GoNoodle investment	Individual and institutional investors, boards of directors/CEOs	Business opportunities with potential for financial returns to the investor	Internal investment criteria and/or conditions set by capital markets	Federal, State, Local	Supply and demand, potential for profit, preferential tax treatment	Spurs innovation, access to large sums of capital	Potential to serve low-income communities in absence of tax preferences or regulatory requirements is unclear
	Dedicated Public Revenues	Dedicated funds raised through taxes, assessments, public fees, or tax credits	Sugar-sweetened beverage taxes (Berkeley, CA and Philadelphia, PA), proposed tax on guns and ammunition (Seattle, WA) , behavioral health tax (Bernalillo County, NM) , employer wellness tax credit (MA) , community development tax credit (NH) , tax increment financing (NE)	Elected officials, voters	Interventions with 1) strong public returns—financial, social, and/or economic, and/or 2) public consensus around the need to address the problem, and/or 3) community champions	Legislative, referenda	Federal, State, Local	Attitudes towards taxes and public spending	Broad-based revenue sources matching the benefit stream of many population health investments, i.e., spread across multiple beneficiaries	Unpopularity of taxes
Sustainable Financing	Earned Income	Money generated from paid work (revenue from sales, fees for services, etc.)	Health information exchange fees, membership fees, contracts for developing community health assessment	Organizations/individuals decide if they wish to purchase given the value they receive in return	When there is demand or a requirement for the service/good on offer (e.g., Health Information Exchange, Community Health Assessment)	Establishing a fair price for the goods/services; this may be negotiated	State, Local	Supply and demand, valuable product for a fair price	Allows multisector partnerships or organizations to capture revenue from the goods/services they create	Establishing a price customers are willing to pay, convincing customers to pay for something previously free or unavailable
	Health Care Payment Model	Value-based payments for certain interventions that specify who gets paid, for what, and payment conditions and terms	Medicare Diabetes Prevention Program (DPP) , Million Hearts, accountable care organizations (ACOs) , chronic care management (CCM)	CMS, state Medicaid agencies, payers, providers, hospitals	Projects that directly reduce health care costs and/or improve health—these typically have some type of clinical component and a short payback period	CMS and/or state Medicaid rules and payers' contractual payment terms	Federal and State Government, Local Payers	CMS requirements, state Medicaid rules, providers' and payers' business models/interests	Payment structures influence shifts in health and cost outcomes, may also create opportunity for reinvestment back into population health	Can require substantial investment, payers/providers may not participate to avoid risk, hard to set incentives right given health system complexity
	Institutional Purchasing and Investment	Institutional purchasing, investment, and employment decisions. Notably, anchor institutions (i.e. sizeable universities, hospitals and employers) can significantly impact local social, economic, and environmental conditions	Mayo Clinic (Rochester, MN) , Henry Ford Health System, Detroit Medical Center, and Wayne State University (Detroit) , Bon Secours Health System (Baltimore) , Kaiser Permanente	Individual institutions	Communities with large institutions	Boards of directors/CEOs and internal resource decisions	Local	Existence of large institutions, institutional goals and/or mission	Large institutions (e.g., hospitals, universities, employers) can significantly impact social determinants of health (e.g., local employment, transportation, environment)	Institutions must decide that purchasing and investment to promote health fulfills their mission and/or there is a business case
	Mandates	Requirements to provide a service/good, funding may be provided or not	Community Benefits, Community Reinvestment Act , Americans with Disabilities Act	Subjects of mandate pursuant to specifications of mandate	Parties with the capacity to fund and/or act on the mandate, a credible means of enforcing the mandate	Legislative	Federal, State, Local	Specifications of mandate, compliance of implementers	Requires spending to meet specified goals	Unfunded or underfunded mandates create financial burdens
	Public Appropriations	Funds are allocated according to impact on health and health costs	Public health (Public Health Emergency Response Accountability Act) , lead poisoning prevention programs , tobacco prevention programs	Government officials	Interventions with 1) clear positive impact on public welfare and/or public spending, and/or 2) a compelling public purpose shared by policy makers	Legislative appropriations and internal management decisions	Federal, State, Local	The number eligible for services (e.g., Medicaid, K-12 education), budget protocols, interest of public officials, public opinion, and competing budget priorities	Opportunity to align public investment across sectors and away from treating costly problems to preventing them	Understanding impact of alternative investments and opportunity costs, buy-in from siloed agencies can be difficult
	Reinvestment	Using savings from health care or other government services (and/or excess revenues) as a source for upstream and downstream investments	Delivery System Reform Incentive Payment Program (NY) , Hennepin Health ACO (MN) , PacificSource coordinated care organizations (OR) , Wraparound Milwaukee (MN) , justice system reinvestment	Payers, providers, purchasers, government officials	Situations in which 1) savings are produced and readily measured, or 2) the reinvested amounts are not cost savings, but a more easily determined amount such as profit margin	Contract negotiation, board decision making, federal requirements	All governmental levels, as well as private sector	Provider and payer business models/interests, state Medicaid rules, CMS pilot program terms	Health care savings and other expenses such as criminal justice are potentially a significant source of sustainable funding	"Savings" are often projected not cash (e.g., costs rise less than otherwise), measurement can be difficult, as can reaching agreement on savings distribution

* Foundation grants typically are not long term and thus not considered sustainable, however, foundations occasionally will make long-term commitments to specific institutions.



Evaluating Possible Financing Structures

Type of Financing Structure: _____

How developed are your multisector partnership or organization's relationships with the decision makers for this financing structure?

(1-No relationships at all; 5-Very developed relationships)

1 2 3 4 5

Rationale (Jot down some notes on why your group picked this rating.)

How familiar is your multisector partnership or organization with the decision-making processes for this financing structure?

(1-Not at all; 5-Extremely familiar)

1 2 3 4 5

Rationale (Jot down some notes on why your group picked this rating.)

To what extent does your multisector partnership or organization have the technical skills needed for success with this financing structure and/or how readily are these skills acquired?

(1-No technical skills; 5-Advanced technical skills)

1 2 3 4 5

Rationale (Jot down some notes on why your group picked this rating.)



How does the likely lead time for acquiring the source of funding match with the timing of your multisector partnership or organization's need for it?

(1-Timing doesn't match at all; 5-Timing matches exactly)

1 2 3 4 5

Rationale (Jot down some notes on why your group picked this rating.)

How well does the likely sustainability of the funding source match with your multisector partnership or organization's needs for funding over time?

(1-Doesn't match with need; 5-Matches exactly)

1 2 3 4 5

Rationale (Jot down some notes on why your group picked this rating.)

Based on your other ratings, how strongly would you recommend that your multisector partnership or organization pursue this particular financing structure?

(1-Not at all; 5- Absolutely)

1 2 3 4 5

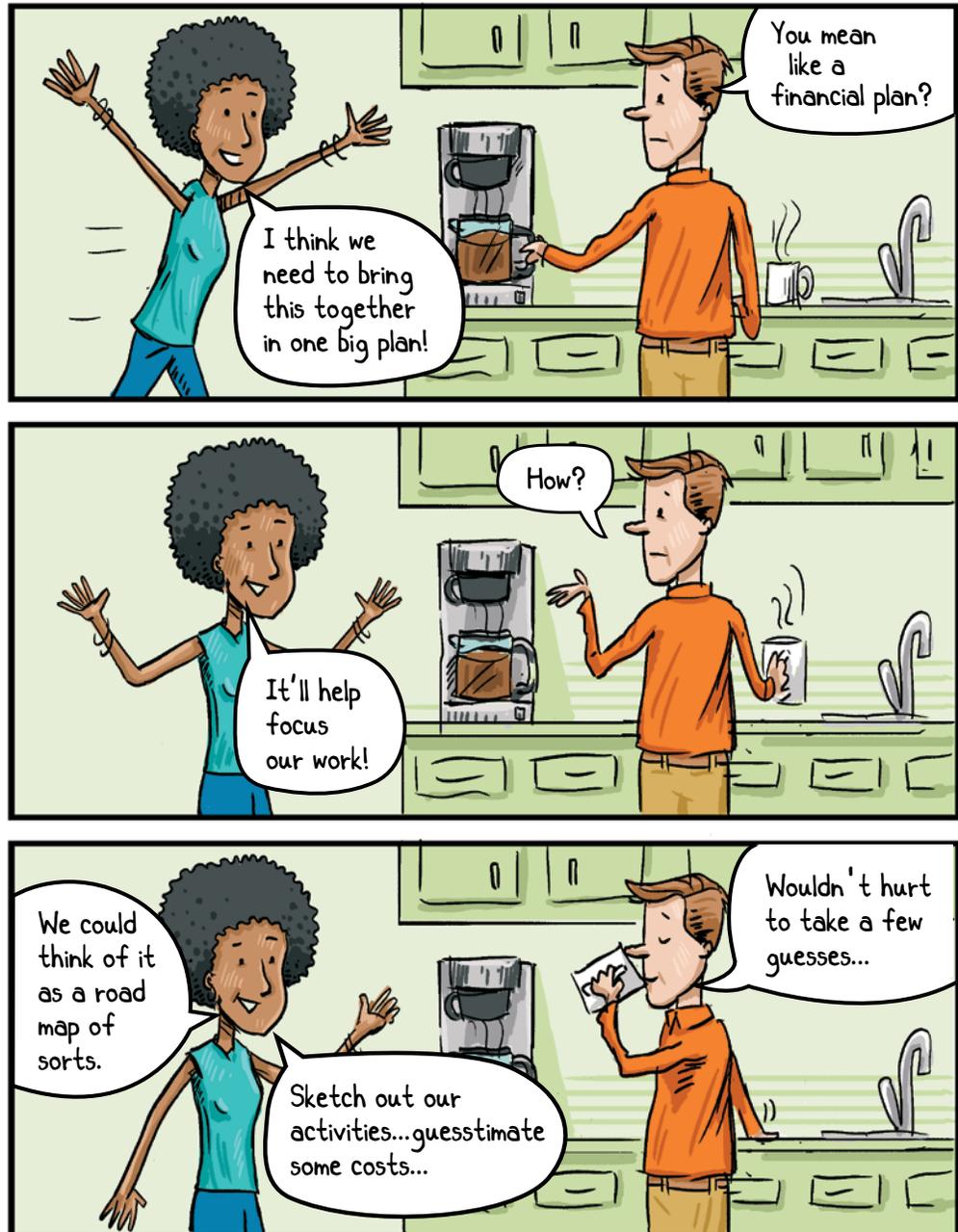
Rationale (Jot down some notes on why your group picked this rating.)

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How Much Will Your Dreams Cost (And How Do You Estimate Those Costs)?

MODULE 4



Creating a financial plan sounds daunting, but it's really important (and painless, we promise!). You'll gain insight into your work just by trying. Don't worry if you don't know the numbers—just dive in!

How Much Will Your Dreams Cost (And How Do You Estimate Those Costs)?

Building a Financial Plan

According to [ReThink Health's 2016 Pulse Check on Multisector Partnerships survey](#), only five percent of multisector partnerships have long-term financial plans. As part of a multisector partnership or organization, you might think that you don't really need a financial plan because you don't have the money yet anyway. But the process of creating a longer-term financial vision brings rewards just for the practice (and will help you figure out where to look for the money, and potentially help you get it), so why not get started?

“The process of creating a longer-term financial vision brings rewards just for the practice.”

Before elaborating on the rewards of just diving in, let's define how we're using the term “financial plan.” For those without a background in finance, the topic can be confusing because finance professionals throw around all sorts of related terms: budgeting, forecasting, financial projections, cash flow projections, sources, and uses. For population health, a financial plan could describe a regional investment portfolio, a multi-year plan for a particular intervention, and/or the funding for conducting integrative activities. All these possibilities make things seem far from simple.

In this workbook, we use “financial plan” as a generic term to describe a schedule of current and future intended uses of money and, ideally, predicted sources of that money. That is, *what do we need money for, how much, where from, and over what period of time?* Creating such a plan is useful at many different levels, whether planning for interventions taken on by multiple organizations across a region or for addressing key integrative activities within a single organization.

With this working definition, we can confidently say you already have the skills to create a financial plan. This workbook is designed to help you along the way. Starting where you are, right now, will help you build the skills, relationships, and conditions that will come in handy when you move on to more complicated financing structures in the future.

A Rewarding Practice

In addition to skill building, there are numerous other rewards just for engaging in the practice of creating a financial plan, including vision, relationship building, alignment, guidance, and greater awareness of opportunities. Consider these examples:

- If you have a long-term, personal financial goal in mind (such as funding your child's college education or your own retirement), then a plan, no matter how bare bones, can help you crystallize your vision. Research on saving for long-term care showed, for example, that even the act of estimating future financial needs on the back of an envelope put families ahead in their preparation for retirement.
- A financial plan—again, even a bare bones plan—can help guide and align decision making. A former budget director for the City and County of San Francisco recalls that the former deputy mayor for finance, for example, kept a small sheet of paper in his breast pocket. It outlined the major points of a plan for balancing the \$2 billion budget. He referred to it often, using it to monitor and guide progress as the budget was developed.



“ A plan can open your eyes
to funding opportunities.

- A plan can open your eyes to funding opportunities. The Northside Home Fund in Minneapolis developed a portfolio to address a neighborhood ravaged by foreclosures (see “A Simple Example” on page 3). When costed out (very roughly), the plan totaled about \$100 million. A consultant on the project recalls people scoffing at the sum at first, but the plan laid out the financial goals so clearly that, several years later, the Northside Home Fund had succeeded in raising almost that much. That’s because the plan created focused priorities so the organization was ready to act when funding sources (such as federal grants, corporate contributions, and state and city housing funds) became available.
- When creating a financing plan you will make assumptions that (by definition) may or may not be true, and you will identify areas where you need more information. Being aware of those assumptions and information gaps will empower you to make more accurate plans and avoid pitfalls down the road. For instance, your intervention may call for community health workers, but their caseloads may already be too heavy to allow room for your intervention at the scale you want. In that case, you’ll either need to fund more caseworkers or scale down your plans.

But What Exactly Is the Practice?

If you’re just starting out, a financial plan doesn’t have to be any more complicated than a household budget. If you’re further along, you can create a more detailed and complex plan. Your choice will depend on where your multisector partnership or organization is in its development and the purpose of the plan. The process of preparing your plan can help you fine-tune your priorities as you develop a better idea of how much things cost and likely revenue sources. But the basic elements, as detailed below, are always the same.

1. **What do you need money for?** Name these items. If your plan describes an investment portfolio, the items would be the list of interventions you’re investing in, such as lead poisoning prevention, prenatal care, and tobacco prevention programs. If you are doing a more detailed plan, you might identify the components of such interventions. For example, lead poisoning prevention could involve lead pipe replacement, blood testing, treatment in children, or lead paint abatement.
2. **How much money do you need (or want)?** Estimate spending amounts for each use you identified in question #1. Obtaining reasonably reliable estimates is easier than it might seem. Ask an expert, go to a source like the [Washington State Institute for Public Policy](#), or simply Google it. Page 5 in this module provides more information on estimating costs.
3. **What are your sources of funding?** Name these sources, along with amounts. You can estimate, or if you don’t know, leave it blank. The Northside Home Fund left it blank, but succeeded in raising nearly the \$100 million the plan called for. See [Module 3](#) for help identifying funding possibilities.
4. **Over what time frame?** Five-to-ten years is a good timeframe. Longer than that, the work gets too speculative. Shorter than that and you may be missing opportunities to use your short-term funding as a bridge to more sustainable options.



A lot of people get hung up on number two, estimating costs. But here's a tip: Do not worry about nailing down precise cost estimates. There are simply too many assumptions that can swing the bottom line one way or another. A far better use of time is to identify key assumptions that make a big difference to your bottom line, and make sure your estimates around these are reasonable. For example, a former director of the Saint Paul, Minnesota Budget Office recalls a staff member there developing a cost estimate for an alternative fire department staffing pattern. The staffer came back with a range (a good idea!), but his range was something like: \$8,561,344 to \$23,869,864. Why create an estimate down to the dollar when the range is so great? \$8 million to \$25 million would have sufficed! But more than that, the large scope of this range suggested that he failed to investigate and nail down key underlying assumptions. A range that big indicates you don't have a clear idea of how it might actually play out: in that case, you have some decisions to make!



THE BEYOND Grant TIP

Do not worry about nailing down precise cost estimates.

A Simple Example

The Northside Home Fund is a multisector partnership created to address blight and disinvestment in North Minneapolis—one of the symptoms of which is illustrated in the map below, where each red pin represents a foreclosure during 2007!

A group from within the city's housing agency drafted a plan and shared it with the broader partnership. The purpose of the plan, the group decided, was simply to outline action steps and how much each might cost.

First, the planning group members decided on a list of objectives that would help achieve their mission of “adding value to existing neighborhood, city, and other private and public efforts to support safe, vibrant, and sustainable neighborhoods in North Minneapolis.” (See Table 1 on page 4) Then, they set numerical goals for each strategy, using their intuition and experience as experts about what was needed, and considering implementation capacity and lead time. These things were tough to pin down at first, but over time group members were able to get more specific and accurate in articulating what they hoped to accomplish and how much of it.

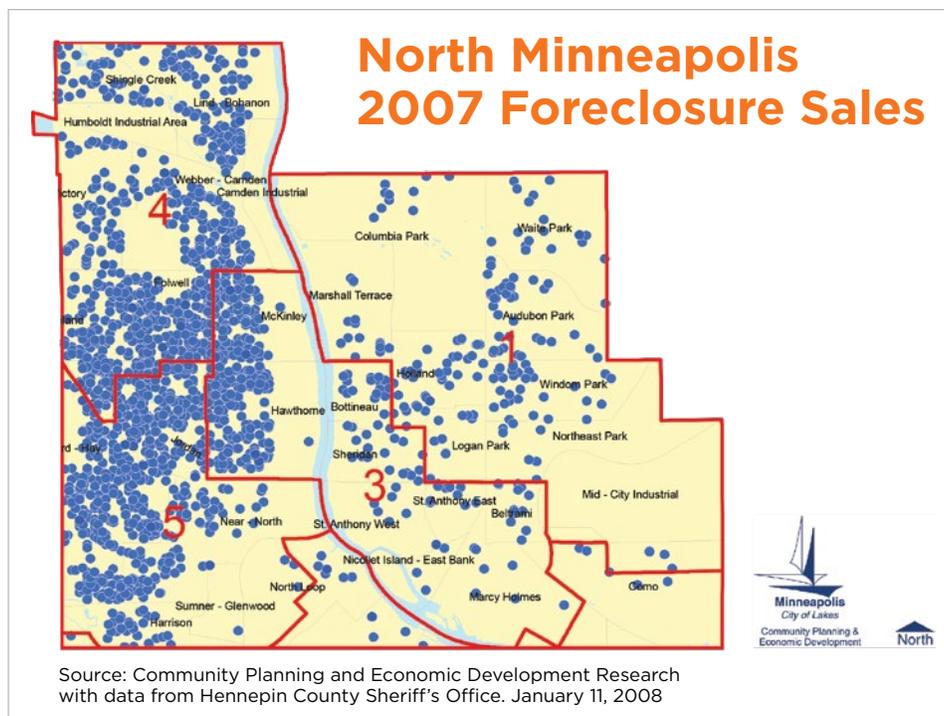


Table 1: Northside Home Fund Work Plan¹

5 Year Work Plan for North Minneapolis					
Overall goal: To recreate attractive, safe neighborhoods and a healthy housing market that is sustainable in the private market.					
Objectives, in annual number of homes	2007	2008	2009	2010	2011
1. Redevelop/rehab all vacant and boarded properties in three years	75	100	100	25	25
2. Prevent properties from becoming vacant & boarded or problem properties	75	75	75	35	35
3. Prevent foreclosures	350	350	300	100	100
4. Attract higher income homeowners to live and stay	200	200	200	200	200
5. Promote reinvestment in North Minneapolis homes and neighborhoods	200	200	200	200	200

Once the planning group members—now participants in a multisector partnership—had set out its objectives and estimated costs, they identified specific interventions to accomplish it (such as refinancing assistance, a marketing campaign, and housing rehabilitation loans) and estimated the unit costs of doing so, again relying on the partnership members’ experience and expertise. The final step was simply to total the costs from all the strategies into a spreadsheet (see Table 2). In this case, the financial resources included both loan funds, indicated in the “loan pool” column, and “grants, program, and subsidies,” shown in the column “Funds.” If more detail was desired, the plan might have indicated the year the loan funds would be distributed, interest rates, and repayment dates. But the purpose of this plan was not analyzing cash flow. The goal was to lay out an effective plan of action and to estimate the costs of that plan.

Table 2: Resources Needed for Northside Home Fund’s Interventions¹

Resources Needed								
(in thousands)								
		Grants, Programs, and Subsidies						
		FUNDS						
	Loan Pools	2007	2008	2009	2010	2011	Subtotal	Total
1-A. acquisition loan pool @ \$125k/home	\$25,000							\$25,000
1-B. subsidies @ \$75k/home		\$5,625	\$7,500	\$7,500	\$1,875	\$1,875		\$24,375
2-A. acquisition loan pool @ \$125k/home	\$14,000							\$14,000
2-B. holding/transaction costs @ \$35/home		\$2,625	\$2,625	\$2,625	\$1,225	\$1,225		\$10,325
3-A. additional funding for Home Ownership Center		\$100	\$100	\$100	\$100	\$100		\$500
3-B. refinancing assistance @ \$7k/home		\$2,450	\$2,450	\$1,400	\$700	\$700		\$7,700
4-A. purchase incentives of \$10k for 125 homes/yr		\$1,250	\$1,250	\$1,250	\$1,250	\$1,250		\$6,250
4-B. forgivable purchase/rehab loans @ \$20k for 75 homes/yr		\$1,500	\$1,500	\$1,500	\$1,500	\$1,500		\$7,500
4-C. marketing campaign		\$50						\$50
5-A. rehab loan pool @ \$10k/home	\$10,000							\$10,000
5-B. subsidies @ half loan pool		\$1,000	\$1,000	\$1,000	\$1,000	\$1,000		\$5,000
Total	\$49,000	\$14,600	\$16,425	\$15,375	\$7,650	\$7,650	\$61,700	\$110,700

¹ Stacy Becker. 2005. Unpublished manuscript.



What was the result?

- The city’s director of housing said, “Every time I would get called to the floor to respond to a City Council issue, I would simply remind the council members that we have a five-point strategy, and read each strategy and rationale—it was like magic.”
- The director of community development said, “It looked audacious then—some banks even said so. And few neighborhood organizations could have predicted that funders would join with banks to feel like a part of the solution instead of an isolated or powerless cog in an investment picture that made no sense.”²

The reason such a simple plan worked is that it focused action and resources, even in unforeseen circumstances. For example, a tornado ripped through the neighborhood, threatening to set back the entire effort. When a few corporations came forward and asked how they could help, the staff was able to respond, “Here’s how.” The corporations donated a total of \$3.1 million.

Estimating Costs

If you are developing a new intervention, trying to determine how much to invest in an intervention, or taking on new integrative activities, estimating costs can seem daunting. How do you know how much something might cost?

There are different approaches to itemizing costs. The best approach for you will depend on the level of detail in your financial plan, the need for accuracy, and the availability of information. **Be aware that no matter which approach you choose, the estimates will be based on numerous assumptions** (e.g., assumptions about salaries, miles traveled, caseloads, or number of people served). One of the most important things you can do is to identify the key assumptions—meaning those that will have the biggest financial impact, such as staffing—and test them out in some way, even if you do something as simple as checking in with colleagues.

Below we outline different approaches to estimating costs, which include: current budget, databases and cost benefit analyses, unit cost estimates, and comparables (if you’re not familiar with those terms, don’t worry, we’ll explain what they mean).

Current budget

A useful starting point is your current budget, which can be projected forward and added to over time—giving you an idea of how big your dreams are compared to your current pocketbook and capabilities. Most organizational budgets are “line-item” budgets, meaning they list specific expenditures: staff salaries, benefits, travel, rent, etc. What’s often missing from such a budget is the set of assumptions behind it, such as workloads for staff or market rental rates. If this information is not available, it can be difficult to develop cost estimates for new interventions.

Databases and cost benefit analyses

For some interventions, you will be able to find published cost-benefit analyses that list total programmatic costs. For example, the [Washington Institute for Public Policy](#) lists total program costs per person, based on costs for the state of Washington. Again, check to see which assumptions are used that may not apply in your state—wage rates, for example, might vary considerably. (For a list of resources, see [Module 5](#).)

² Elizabeth Ryan. Personal correspondence with Stacy Becker



Unit costs

Sometimes you must estimate costs from scratch. An easy way to do this is to use a unit cost method. Unit costs are the cost for each of something, such as the cost per community health worker. Estimating costs using the unit cost method requires you to identify “how many do we need?” for each component, and “what is the cost?” for a single item. For example, in our *Financing Wizard*, we feature a case study around lead abatement. If we want to remove lead from 100 homes per year at a unit cost of \$10,000 per home, our annual cost would be \$1 million (100 homes x \$10,000 per home = \$1 million).

Here are a few tips for using the unit cost method:

- Identify whether your components are fixed or variable. Fixed means that it’s a set cost that won’t get bigger as more people are served, such as purchasing a software program. Variable means that the expenditures depend on the amount of service provided—typically the number of people served, but it could be other things as well, such as the number of homes. Let’s use the lead abatement case study as an example again: the number of tests for lead poisoning increases with the number of people you wish to serve; the number of lead paint inspections or case worker visits will increase with the number of homes you wish to include in the program. Sometimes, there may be a hybrid. For example, rent is fixed until the number served exceeds available space. Software might come with 10 free licenses, after which they must be purchased.
- For the variable costs, take an educated guess about the level of service you will provide, such as how many people you’ll serve each year or the number of affordable housing units. Then identify any assumptions linked to this service level. For example, if you are serving people through community health workers, you’ll want to identify assumptions such as the caseload per community health worker, or the cost of reimbursing workers for travel expenses. This will tell you how many units of something you need. For example, if you’re serving 200 people and community health workers can each serve 50 per year, you’ll need four community health workers.
- There are readily available resources for estimating unit costs and related assumptions. One source is the internet. If we were building out the lead abatement case study, we could try searching, “cost of lead abatement” or “salary of a community health worker,” for example. Tougher questions, but still available from the internet are things like “what is the annual caseload of a community health worker?” Another approach is to consult those in the community with experience in such matters.

Comparables

In real estate or human resources, appraisers use comparables, or comps, to set prices for a building or land, or for salaries or wages. In some cases, you might want to search out comps to identify an appropriate range of costs. Can you think of a comparable type of good or service? How is it priced? Here are some examples:

- If you are conducting integrative activities, you might compare them to the work done by a grant-making foundation, where five-to-ten percent of total budget is devoted to managerial and administrative activities.
- Perhaps you are offering a service similar to one already provided internally by a payer? For example, some health plans offer community-based services such as case management and community health workers. Knowing their costs can give you a sense of the price range that potential payers might find acceptable. Often, the best way to do that is to contact that organization and ask.



Final Tips

Before you get started, we want to acknowledge that we may have made things sound simpler than they really are—but that’s on purpose, because we don’t want you to get too caught up in trying to make it perfect; **it’s fine to keep it really simple.**

“ A first pass should be simple—treat the plan as a discovery process.

- General rule of thumb: the more you guesstimate your inputs, the simpler you should keep the rest of the details. It doesn’t do any good, for example, to work really hard on nailing down the price of a \$15,000 piece of software if you have no idea of how much it might cost to remove lead from houses.
- A first pass should be simple—treat the plan as a discovery process. The process of trying to complete a plan helps you understand where you need better information, and to which variables your plan is most sensitive.
- Even a simple plan can contain vital information—part of the idea of putting numbers down on paper is to begin to convey to others the financial resources needed for success, and to secure the necessary commitment to acquiring those resources.

When you have all the costs totaled up, don’t shrink from the price tag. Go back and revisit your plan if necessary. But remember this: while your long-term plan might look daunting and you might fall short, you definitely can’t get there if you don’t strive for it.



The ReThink Health Financing Wizard

Ready to explore financial plans a bit more? The ReThink Health *Financing Wizard* is for you!

While the “Financial Planning Template (Basic)” on pages 8 and 9 is a good way to get started on a financial plan, if you want to go into more detail after completing that (or even dive right into the details), the *Wizard* has a robust template you can use to do much more specific planning and projection.

Available for download from our website (<https://www.rethinkhealth.org/financingworkbook/Financing-Wizard>), the *Financing Wizard* is a tool with two key features:

- A population health case study that gives you some context and the opportunity to create a financial plan around it. It’s an easy way to practice estimating costs and putting them in the context of a financing plan.
- A Microsoft Excel-based financial plan template that allows you to practice creating a plan for your organization’s activities.

Our *Financing Wizard* takes some of the uncertainty out of creating a financial plan and allows you to experiment. It’s an easy way to get in some of the practice that is so essential to financing!

If you have any questions about the *Financing Wizard*, please email ThinkWithUs@rethinkhealth.org.



WORKSHEET

Financial Planning Template (Basic)

MODULE 4

OBJECTIVE: To begin assembling a basic financial plan.

TIME: 30-60 minutes, depending on how many activities are associated with your intervention

MATERIALS: One copy of this worksheet (for leading the exercise)

PARTICIPANTS: A few members of your multisector partnership or organization who are familiar with the activities around a particular intervention, or who are working together to plan an intervention.

Directions

Use the table below to draft your basic financial plan. Don't focus too much on getting it right—just get something down. You can refine and build it out as you go. This template is set up similarly to the Northside Home Fund example shown from earlier in this module.

In Part 1, below, list out your **Key Assumptions**. Begin by writing the goal of the intervention in the first row. Underneath that list out the specific activities you'll engage in to accomplish that goal. For example, your activity might be to rehabilitate houses. To the right, in the Year 1-Year 5 columns, list out how much of those activities you'll be doing. For example, if your activity was to buy plots of land for community gardens, you'd estimate how many plots you'd buy each year. Part 1 is to give you a space to start to think about the scope and scale of your intervention, before you try to estimate costs in Part 2.

In Part 2, estimate the uses (costs) and sources (revenue) associated with your activities listed in Part 1. Under **Uses**, get more specific on the major costs or expenses required to bring your intervention to life—e.g., hiring, acquiring land or equipment, training, or communications. **Start Up** costs are costs that you estimate you'll incur just to get the program off the ground. **Year 1-Year 5** are costs you think you'll incur as you deliver the intervention. Under **Sources**, make ballpark estimates of revenue sources, again categorizing them into revenue that might be available in your start-up phase and revenue that will be available over the duration of your activities.

Part 1: Key Assumptions

Goal:							
Key Assumptions							
Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total	
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							



Part 2: Uses and Sources

Uses	Start Up	Year 1	Year 2	Year 3	Year 4	Year 5	Total

Sources	Start Up	Year 1	Year 2	Year 3	Year 4	Year 5	Total

Congratulations! You've developed a basic financial plan!

When you're ready to get more detailed, move on to our Financing Wizard at:
www.rethinkhealth.org/financingworkbook/Financing-Wizard

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What Value Do You Create?

MODULE 5



You know your work is valuable, but how do you demonstrate that to others? ReThink Health's Value Sequence can help you identify the value you create, add evidence, and successfully "make the case" for funding.

What Value Do You Create?

Finding Your Return on Investment

As part of a multisector partnership or organization, you know you are doing valuable work. This module offers guidance on how to demonstrate that value to others. In order to attract the dollars necessary to support your work, you'll need to "make the case"—why should anyone give you money for this purpose? Often this case is built on a calculation of "return on investment" (ROI).

There are several different contexts for needing to calculate ROI. We're going to highlight three:

1. You're assembling a portfolio of interventions and want to know the ROI on a large number of interventions in order to select the ones that provide optimal returns given the goals of your portfolio. Sometimes it helps to think of a portfolio of interventions as similar to a personal financial portfolio. Most investors have an assortment of investments that, together, help them accomplish their goals. They expect a certain ROI from everything in that portfolio. For you, picking particular health interventions based on their ROI might be similar. You might first decide you want a group of interventions with high ROI (this is similar to buying stocks of well-established companies that frequently share their profits with investors via dividends); then, from that group, you might pick the actual intervention from that list (like an investor might pick a particular stock such as Apple, Kraft, Heinz, or Visa).
2. You're planning a newly conceived intervention that hasn't been tested out in any other communities/organizations.
3. You're interested in the ROI of interventions and/or integrative activities that you are already implementing.

Presumably, all the work involved in these three contexts has value attached to it because it creates some type of good in the world. (If it didn't create value, you wouldn't be doing it, right?!)

This module, and the accompanying worksheet, will help you develop evidence for the value you are creating or hoping to create. They describe three methods for identifying value and supporting it with evidence. A special section in the worksheet is devoted to thinking about the value your integrative activities create.

Financial value—value that can be monetized—is only one type of value. Sometimes financial value will be very important; other times, much less so. Other types of value include:

- Social value, such as reduced crime or improved quality of life for the general population.
- Economic value, which typically attempts to place a dollar value on social benefits—such as longer lives—to quantify the effect they will have on the economy.
- Other factors that organizations might value because they advance the organization's mission or enhance its reputation or competitiveness (such as quality rankings).



Financial value—value that can be monetized—is only one type of value.

Value: Who Benefits?

Throughout this module, it's important to consider *for whom* you are creating value. That knowledge will help you more accurately evaluate the impact various courses of action will have on your goals. It will also help you identify which stakeholders will benefit from your actions (and might be willing to help fund them as a result).



It's very possible that the organization you are seeking payments or investments from cares much less about financial return than these other forms of value. A good rule of thumb is always to form relationships with potential funders and learn what it is that they most care about. For example:

- When asked about ROI and its decision to invest in clean air, a hospital system responded, “We don't need an ROI. It's obvious that clean air is a good thing.”
- A multisector partnership presented a group of commercial health plans with evidence of ROI resulting from an intervention to reduce heart attacks and strokes. The group of commercial health plans responded that the ROI wouldn't convince them, but they did care about HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Healthcare Providers and Systems), which are common measurements of health care service. Currently, 50 percent of the total score for health plan accreditation is driven by performance on HEDIS and CAHPS.
- Philadelphia passed a sugary drinks tax that succeeded where others failed. Many credit the innovation of tying the proceeds to investments in services voters cared about, notably early childhood education¹.

Also, be aware of possible pitfalls when trying to demonstrate financial ROI—especially if payment is contingent on ROI, as is the case with some shared-savings arrangements or social impact bonds. The more complicated the situation—and population health tends to be complex—the greater the number of assumptions that must be made to conduct the analysis. Check out [The Sense and Nonsense of Using ROI for Population Health](#)², a post from The ReThinkers' Blog, for more on the topic.

Demonstrating to Others the Value of Your Work

Ideally you are building relationships with funders to discover what they care about. Is it only financial value? Or other types of value? Your next task is to demonstrate the value that your work creates to the people and organizations you want to convince (potential funders, stakeholders you're trying to enlist, etc.). The remainder of this module lists three different ways to do that, culminating in a worksheet—found on page 6—that will step you and your colleagues through one of those ways: a process of identifying potential value by thinking very concretely about the specific activities you engage in and the unique value they create.

1. Instant ROI: Search the Existing Evidence

If your intervention is evidence-based, you may find that the ROI and/or cost-benefit ratio has already been calculated. (“Evidence-based” means that the research meets certain high standards³.) Below, we've listed some evidence you can use as a starting point when evaluating interventions. (Unfortunately, in comparison, the evidence for the effectiveness of integrative activities is limited—see [Appendix 2](#) for brief summaries of what we were able to find.) If you're using a print version of this module, we've tried to include enough information to allow you to easily find the websites using a search engine.

Resources

First, some resources that may help you evaluate interventions.

[The Washington State Institute for Public Policy](#) has conducted meta-analyses (analyzing the results of numerous studies on the same topic) of interventions that directly or indirectly relate to population health. The following information is provided for each intervention: cost; benefits broken down by recipient (e.g., taxpayer, participant, or other), benefits broken down by sector (e.g., health care, crime, labor earnings), the time horizon over which the benefits accrue, and sensitivity analyses around costs and the likelihood that benefits will exceed costs. The data are based on the conditions in the State of Washington, so you may need to make some adjustments. However, the analyses are very robust and you would be hard pressed to find better data anywhere—and it's free!

¹ Margot Sanger-Katz. 2016. “Soda Tax Passes in Philadelphia. Advocates Ask: Who's Next?” *The New York Times*, June 16, 2016, <https://www.nytimes.com/2016/06/17/upshot/soda-tax-passes-in-philadelphia-advocates-ask-whos-next.html>.

² <https://www.rethinkhealth.org/the-rethinkers-blog/the-sense-and-nonsense-of-using-roi-in-population-health/>

³ For example, WSIPP uses this definition: A program or practice that has had multiple site, randomized controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.



Kansas Health Matters, created by the Kansas Partnership for Improving Community Health, helps professionals and community members explore documented approaches to improving community health and quality of life.

The Results First Clearinghouse lists the effectiveness of various interventions as rated by nine national research organizations.

The Case for Investing in Public Health, a publication of the World Health Organization, identifies the financial returns of “best-buy” interventions, categorized by risk factors, health outcomes, healthy behaviors, social determinants of health, environmental health, and vaccinations and screening.

Databases

These may help you locate the ROI or cost-benefit for your specific intervention.

The Agency for Healthcare Quality and Research has a searchable database of more than 700 studies specifically related to population health. In very straightforward language, the site provides summaries of the evidence, an evidence rating, and implementation specifics.

The Community Preventive Services Task Force’s Community Guide asks for your role (e.g., policy analyst, employer) and purpose (e.g., seeking funding, community health needs assessment) and returns a list of tools and resources, including relevant fact sheets.

The Centre for Review and Dissemination at Great Britain’s National Institute for Health Services and the University of York provides a searchable.

The Community Health Improvement Navigator from the Center for Disease Control is a database providing results of single studies as well as meta-analyses on interventions. The database allows you to filter for risk factors, specific populations, desired outcomes, intervention settings, intervention types, and the type of assets that helped carry out the interventions.

The National Registry of Evidence-Based Programs and Practices provides information on effective behavioral health programs.

Community Tool Box offers a one-stop resource: a database of best practice databases, with links to comprehensive resources as well as resources categorized by topic (such as cancer, community development, and violence prevention).

Health Services Research Information Central of the National Institutes of Health provides a large database of online health data, tools, and statistics.

What Works for Health from County Health Rankings & Roadmaps lists more than 150 categories of health interventions rated as “scientifically supported,” summarizes the evidence, and provides links to the literature.

What Works for Health, Policies and Programs to Improve Wisconsin’s Health is exceptional for its visual presentation and ease of use. In addition to recounting the evidence, the database also lists implementation resources.

Value in Health, a journal offering original research on outcomes in the areas of pharmacoeconomics, and health economics; describes itself as “translating outcomes research to health care decisions.”



If your intervention is evidence-based, you may find that the ROI and/or cost-benefit ratio has already been calculated.



2. Conduct an Evaluation

If your intervention is a pilot program, you may want to conduct an evaluation; the type of evaluation will vary depending on its exact purpose. Good evaluations are likely to cost on the order of 10 percent of the total programmatic budget. Moreover, a single analysis is usually insufficient to propel a pilot into the “evidence-based” category. But the evidence trail has to start somewhere, and if the pilot program is of great importance to you, you may want to hire an evaluator.

There are many types of evaluations. Below we list a few websites (that you can find with a search engine) that can help you decide what type of evaluation is best suited for your needs. In making this determination, you’ll want to consider:

- **Why do we need this evaluation?**
- **Who is the audience—what evidence will they require and how rigorous must it be?**
- **What data are accessible? Will we need to pay for that data, or obtain special permissions? What time lags are there between the occurrence and the reporting of the data?**
- **What do we have, in terms of financial and staffing resources, to support this evaluation?**

The American Public Human Services Association has published a useful overview and guide to evaluating social return on investment. This guide offers examples and tips that will help you manage your evaluation well.

BetterEvaluation is an international collaboration to improve the practice and theory of evaluation. Its website offers a step-by-step process for determining what type of evaluation process works best for your needs.

Centers for Disease Control and Prevention’s website provides a number of valuable resources for evaluation, and also lists upcoming events and trainings.

Great Britain’s National Institute for Health Research provides an **online toolkit** for developing appropriate evaluation plans for social and health care services.

Finally, in order to conduct an evaluation that yields the most useful information, it’s important to understand the process by which your intervention produces value. Constructing a value sequence (see below) can help help frame your evaluation.

3. Construct a Value Sequence

In all other cases—for example, integrative activities, when your intervention doesn’t show up in any existing ROI or cost-benefit databases, or when you don’t have the time and resources to conduct an evaluation—you might want to consider using the “Value Analysis” worksheet starting on page 6. The worksheet will show you how to compile and organize existing evidence into documentation of value and help you identify where weak links might exist.

Most often, when dealing with population health, an intervention puts in motion a chain of causal events intended to create health. For example, a smoking cessation program may lead someone to stop smoking, which will improve the health of the person’s lungs, which may prevent lung cancer, which prolongs life, reduces suffering, and reduces medical costs—so while these steps create value for the smoker, some also benefit the economy overall, as well as the organizations that value reduced medical costs.

Each step in the causal sequence has its own uncertainties—we are dealing with human beings and complex societies after all. Identifying the sequence of events that produce value helps make explicit the process by which we assume health will be produced in your region and enables us to analyze the strengths and weaknesses of our assumptions. Simply stepping through these assumptions has value as an exercise on its own; stepping through the entire value sequence brings added benefit.

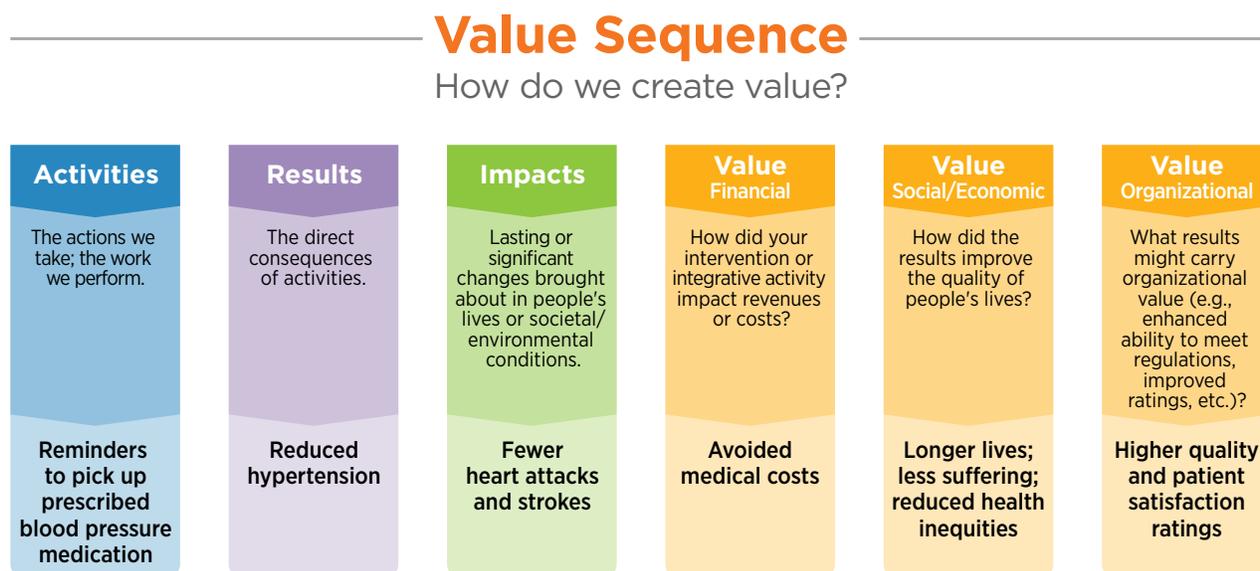
¹ Stacy Becker. 2005. Unpublished manuscript.



The worksheet will walk you through a simple exercise to identify the value sequence you are creating from an intervention or integrative activity. It consists of identifying these steps in the value sequence:

- **Activities:** The actions we take; the work we perform.
- **Results:** The direct consequences of activities.
- **Impacts:** Lasting or significant changes brought about in people's lives or societal/environmental conditions.
- **Value:** Expressing impacts in terms of things that people and organizations care about (e.g., financial, social, and economic gains and losses; organizational reputation or competitiveness).

A simple example of a value sequence is shown below, starting with the activity, "Remind people to pick up their prescribed blood pressure medication."



Creating a complete sequence will help you think about how you might answer questions such as:

- Do we have enough evidence to convince those we're trying to convince?
- What pieces of the evidence are most persuasive/relevant to different stakeholders?
- Are there weak links in our value sequence? If so, should we modify our intervention or activity in some way to strengthen those weaknesses?
- What is the likelihood that we'll capture the financial and/or social/economic value we seek? What does that rest on?
- Who might be willing to pay for such value?
- How might we develop a payment model based on this value?

We've noticed it's often more difficult to do this analysis with integrative activities compared to interventions because people or organizations carrying out integrative activities often dismiss those efforts as being of little value. Furthermore, they often don't have a clear idea of all they do (and if you're not sure, [Module 7](#) can help). But stick with it! The more detailed you can be, the easier it will be to articulate the value you create through your integrative work.

As you step through your value sequence you may find the distinction between activities, results, and impacts confusing at times. That's okay; go with whatever makes the most sense to you and don't get too tripped up (particularly on the difference between results and impacts). There's going to be a lot of insight into your work and the value you create no matter what "bucket" it falls in.



WORKSHEET

VALUE ANALYSIS



OBJECTIVE: This exercise will show you how to compile and organize existing evidence into documentation of value and help your multisector partnership or organization identify where weak links might exist.

TIME:

- Steps 1 through 4 (value sequence creation): about one hour
- Steps 5 and 6 (adding evidence and interpretation of results): about one-to-two hours, plus whatever time you need for research—which will depend on availability of information and the level of confidence your audience will need

MATERIALS:

- One copy of this worksheet (for leading the exercise)
- One copy of the Value Sequence Template (see page 10) (you may want to enlarge it)
- Medium or large sticky notes

PARTICIPANTS: The leadership team and other members of your multisector partnership or organization, as well as other stakeholders. There's no minimum number, but the more heads you put together, the better.

This is a six-step exercise. It is actually quite simple—and effective!—if you work through it step-by-step. It will help to read through the worksheet first—to get a better idea the full process—but once you start working through the exercises, *resist the temptation to jump ahead!* The worksheet is most effective when completed in order.

To demonstrate the value of your intervention or integrative activity, you will populate the Value Sequence Template, and then try to quantify the relationships as best you can. In this exercise, you will answer the following questions:

- What are all the activities involved in any given intervention or integrative activity; that is, what do we do? (For a list of integrative activities, check out [Appendix 1](#))
- What things happen as a result?
- Where do the results fit in the value sequence?
- What's the evidence? Any spots in our sequence where the available evidence is weak?

STEP 1

Activities. On separate sticky notes, list all the activities performed or services provided as part of your intervention or integrative activity, then place them on the Value Sequence in the boxes under the heading “activities.” For example:

- Cardiovascular initiative: screening, home blood pressure monitoring, medication reminders, health counselors, etc.
- Free clinic: primary care services, referrals to specialty care, translation services, screening services, etc.
- Integrative activity: engage stakeholders, build public will, enroll others in advocacy via convening/organizing, determine agenda, facilitate connections and one-to-ones among key leaders, create detailed meeting design, etc.

STEP 2

Results. Now list on separate sticky notes all the good results that happen because you engaged in these activities: how is the world better because of these activities? Keep in mind impacts could be a couple of steps removed from the original beneficiary. Here are some examples of results:

- More people have their blood pressure under control
- Better attendance at school
- Reduced trauma
- Fewer low birth weight babies
- Fewer emergency room visits
- Reduction in medical costs
- Reduction in prison costs
- Reduction in health inequities
- Less crime
- Greater alignment in regional spending
- Coordinated community health assessment



BEYOND THE Grant TIP

You might find that it's difficult to brainstorm the results of your integrative activities. Think about it this way: what would not get done if you didn't do these things? That may help you itemize all the many things you help make happen.

STEP 3

Sorting. Sort all the results under the proper heading in the value sequence. **Don't worry too much about the exact category**, particularly whether something goes under "results" or "impacts." It might help to think about the sequence in three primary buckets: what you do (activities), the effect it has (results and impacts), and the value it creates and the value it creates (financial, social/economic, and organizational).

- **Results:** What direct effect did your intervention or integrative activity have?
- **Impacts:** What lasting or significant changes have you brought about in people's lives or their environment?
- **Value:**
 - **Financial value:** How did your intervention or integrative activity impact revenues or costs?
 - **Social or economic value:** How did the results improve the quality of people's lives? These sometimes have a price tag put on them so can be expressed as "economic value," such as the costs of victimization from crime. These differ from financial value in that they wouldn't appear as actual revenues or expenditures on an organization's balance sheet.
 - **Organizational value:** What results might carry specific value for organizations, such as enhanced ability to meet regulations, improved quality rankings, greater patient satisfaction, or a competitive edge?



BEYOND THE Grant TIP

If you have a particular outcome that you care especially about, such as health equity, job creation or improvement to the environmental quality, you might want to add a special "value" or "equity" column just for this. This will help you analyze the contribution your intervention or integrative activity are making toward that goal.



STEP 4

Discussion and refinement. You now have a first draft of your value sequence! Take a look—does it convey the value you believe you create? Is anything missing? Discuss the results and make any desired refinements.

STEP 5

Adding Evidence. Once you have developed your value sequence, it's time to become a sleuth and go looking for pieces of evidence that support it. You want to use evidence to make your case as solid as possible.

- **Interventions:** Interventions don't have monolithic effects—they work on some people and they don't on others. So each step in the sequence above will have a probability associated with it—the expected number of people the intervention will be successful with. Think of this in terms of percentages. What percentage of eligible people who receive the reminder will pick up their medication? What percentage of those who pick up their medications will take them as instructed? What percentage of those complying with the directions on their medication will see reduced blood pressure as a result? What percentage of those with reduced blood pressure will avoid a heart attack or stroke? In the end, only a fraction of those who receive the reminder will experience the intended impact of fewer heart attacks. Let's pretend, for example, that we start with 100 people (and apply hypothetical probabilities):

 **100** people receive reminders

 **90%** pick up their medications = 90 people

 **80%** of those who pick up their medications also take their medication as prescribed by their health care provider (amount, frequency, etc.) = 72 people

 **85%** of those who comply with instructions have reduced blood pressure = 61 people

 **40%** of those with reduced blood pressure avoid a heart attack = 24 people

24% Success Rate

So, if the only impact you're concerned with is avoidance of heart attacks, you can expect 24 fewer heart attacks out of 100 people to whom you send a reminder (a 24 percent success rate).

As you just saw, the value created by your intervention will depend on the probable effectiveness at each step in the sequence, so, if possible, do not overlook any steps. Also, to ensure the ultimate value creation is accurate, build a solid evidence base to support your contention that your intervention produces the intended impacts.

Finding the evidence is not as difficult as it may seem; there is a great wealth of information out there. The list provided under "Instant ROI," on pages 2 and 3, can help you track down what you need. Note that the information you want may be the subject of an entire research study, or it may be buried in a single paragraph. What you're looking for is any information (preferably with numbers attached to it) that estimates the effectiveness factor of a step in your value sequence and/or assigns value to your impacts. Finding this information will help you make the right decisions to maximize your desired impacts, and it will build confidence in your plan—both with stakeholders and yourself.

Expect wide-ranging differences in results. Research studies are not identical: variations in populations, interventions, dosages, and methodologies impact the results. For example, we compiled an estimate of the financial impact of having hypertension "under control," and found results ranging from \$513 to \$4,738 per year. That's a big difference! And it illustrates the measurement difficulties inherent in demonstrating ROI. Some stakeholders might question wide variations in results; some might not. Be prepared for either response. Carefully select evidence that most closely resembles your own circumstances and be prepared to explain to stakeholders and funders why you thought that evidence was relevant.

- **Integrative Activities:** The tricky part about integrative activities is that these essential services tend to be so undervalued—we’re betting you know that from experience! Yet we take the importance of these activities for granted in virtually every other type of organization, whether it’s public, private, or even social. Think about it this way: without multisector partnerships or organizations taking on integrative activities, the population health interventions you are working so hard to implement would never get accomplished.

A value sequence for integrative activities probably won’t look as complete as the sequences you could develop for interventions. The “evidence” you are looking for will likely be of a very different sort, as will the sources of information. The results you identify in Step 2 may be in the form of “deliverables,” such as the production of a coordinated community health assessment or the acquisition of funding for an intervention, so the evidence may speak for itself. As a result, the very process of articulating a value sequence may help clarify important objectives for your integrative work.

But don’t gloss over the financial impacts. For example, a [2012 study by Deloitte](#) showed that effective senior leadership can add up to 15 percent of a company’s value⁴. And a [2006 study of 94 companies](#) found a dramatic correlation between financial performance and transformational leadership practices⁵.

What’s more, in the nonprofit sector, higher performing charities had somewhat higher administrative costs than lower performing charities⁶.

To the extent that your integrative activities cause something to happen, such as the implementation of an intervention, and that intervention has financial impacts, a portion is attributable to those leadership and management functions—just as they are in any business or nonprofit organization. The National Council of Nonprofits makes this point in its report, [Investing for Impact, Indirect Costs Are Essential for Success](#)⁷, and Nonprofit Quarterly’s article, [“Why Funding Overhead is Not the Real Issue: The Case To Cover Full Costs”](#)⁸, is also a great resource on this topic.

STEP 6

Interpreting Information. Look at the picture you just completed. Maybe your evidence chain is robust and full; maybe it’s sparse and lacking. Maybe you found some surprising positive evidence; maybe you discovered some weak links in your sequence. You can use your results to answer the following questions:

- Do we have enough evidence to convince those we’re trying to convince?
- What pieces of the evidence are most persuasive/relevant to different stakeholders?
- Are there weak links in our value sequence? If so, should we modify our intervention/integrative activity in some way to strengthen those weaknesses?
- What is the likelihood that we’ll capture the financial and/or social/economic value we seek? What does that rest on?
- Who might be willing to pay for the value we create? Does our value analysis suggest a suitable financing source or payment model?
- Does the value analysis suggest a few reasonable indicators that can be used to monitor results? For example, perhaps there’s a key variable with a high effectiveness factor that is particularly important to achieving results in the value sequence. For example, if med bundles are highly effective in reducing hypertension, you may want to invest more heavily into them. On the other hand, if there’s a weak link (low effectiveness factor) in the chain, you may want to specifically monitor the performance of that link, since it could impact your overall value sequence.

⁴ Deloitte. 2012. “The Financial Impact of Executive Leadership.” September 5, 2012. <http://deloitte.wsj.com/cio/2012/09/05/the-financial-impact-of-executive-leadership/>.

⁵ International Leadership Associates. 2007. “The Business Case — The Five Practices of Exemplary Leadership.” September 2007. <http://i-lead.com/lchallenge/the-leadership-challenge-model/the-business-case/>.

⁶ Caroline Fiennes. 2015. “Charities and Administration Costs.” *Giving Evidence*. <https://givingevidence.files.wordpress.com/2013/05/admin-costs-re-release-dec-20151.pdf>.

⁷ https://www.councilofnonprofits.org/sites/default/files/documents/investing-for-impact_0.pdf

⁸ <https://nonprofitquarterly.org/2018/09/12/why-funding-overhead-is-not-the-real-issue-the-case-to-cover-full-costs/>

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Value Sequence Template

Print on Tabloid (11x17) Paper.

Activities	Results	Impacts	Value Financial	Value Social/Economic	Value Organizational

How Much Should You Charge for Your Services?

Once you and your multisector partnership or organization have decided which interventions to pursue, what's next? This module addresses a specialized case: the case in which you seek funding from a payer(s)—e.g., an insurer, private employer, or the government—for a specific intervention or integrative activity. Oftentimes, this is done through a health care payment model. In other words, you want them to pay for a specific service you are providing to them. This module will help you think about how to price your services.

Once you've completed your value sequence and return on investment (ROI) analyses (by completing [Module 5](#)), you'll have a good idea how much value an intervention or integrative activity creates and for whom, and to what extent you might be able to turn that value into income. The next step is to convert that information into a revenue stream. This module will guide you through the following questions:

1. Who might be willing to pay?
2. What is our revenue target?
3. How do we structure a price?

In the field of population health, there is a great deal of emphasis on demonstrating ROI. Knowing the ROI of an intervention helps ensure we make good investments and helps make the case for funding. But ROI may not be the deciding factor in whether or not a payer will purchase your services.

Indeed, many variables influence payers' decision making. These include mission, organizational reputation, political considerations, organizational priorities, power dynamics, competitive pressures, risk tolerance, and regulatory considerations. This chapter will help you navigate these variables.

In the end—even with a strong ROI—your success in acquiring funding will be dependent on becoming an astute observer of your working environment, forming important relationships, and building your persuasive powers and negotiation skills.

Who might be willing to pay?

Look at the results from your value sequence ([Module 5](#)) and system analysis ([Module 2](#)) and ask yourself who might be willing to pay for the value you're creating. Consider:

- Is the value financial in nature (i.e., monetary returns) or is it social, economic, or organizational? That is, is there cash associated with the value?
 - If there's financial value, is it in the form of revenue, cost savings, or avoided costs? Avoided costs are costs that you would expect to incur in the future, but can be avoided entirely or in part through the intervention. Note that avoided costs are important financial returns, but they don't automatically produce cash flow that can be shared.
- How much and what type of evidence will potential payers expect?
- What is your relationship with potential payers? What is their decision-making process?

To help you with this analysis, consult *A Typology of Potential Financing Structures for Population Health* ([Module 3](#)). The *Typology* categorizes various sources of funding by the type of decision makers and decision processes involved. It also indicates how important an ROI is likely to be in the decision-making process.



What is your revenue target?

How much money do you want? It seems like an easy question if you have information, but nearly impossible if you are lacking information about key variables. For example, how much of a mortgage do you want for a house? This will depend on the price of the house you are buying, how much the bank is willing to lend you, and the size of your down payment. If you know none of these things, it will be nearly impossible to answer the question of “how much?”

Likewise, when seeking funding for an intervention, the question of “how much?” depends both on the costs associated with that intervention, as well as what is feasible to expect from specific funders. It’s useful to start by identifying a range.

First, set the lower bound equal to your costs. Presumably, you’d like to cover your costs at a minimum. If you haven’t yet estimated your costs, now is a good time to do so, and [Module 4](#) can help you with that process.

Then, set the upper bound, which should be an estimate of value to the payer. Presumably, payers won’t pay more than what they perceive to be the value to them. [The Value Sequence \(Module 5\)](#), the [“Considering Costs and Benefits” worksheet \(Module 2\)](#), and [A Typology of Potential Financing Structures for Population Health \(Module 3\)](#) all point out that the same product or service has different financial value to different potential payers; treat that value as an upper bound.

For example, one multisector partnership was paid by local hospitals to conduct a joint community health needs assessment because each avoided the full costs of conducting its own assessment—the upper bound for each payer.

Now you have a sense of the boundaries for your funding request. It is possible that the range is quite large. In this case, a large range is okay. As you approach potential payers or investors, you are likely to be in a negotiating situation, so your range is just a starting point. As you engage in negotiations the range will likely get smaller, and eventually you’ll settle on an acceptable number.

It’s also possible that the value to any single payer will be less than your costs. In this case, assuming you have scaled your costs down to a minimum, you need to seek funding from multiple payers and/or seek grants to cover your full costs.

How do you set a price?

Now that you have a revenue target for your intervention, the next step is to figure out a pricing structure. While the final determination of price will likely result from some type of negotiation process, it’s important to understand your costs in relation to risk, and designing a pricing structure can help you do that.

Price is more than “how much?”; it also must address “for what unit of goods or services?” This can get tricky, but in a value-based pricing environment, where outcomes matter, fee-for-service is no longer always an option. Increasingly, providers are paid based on the value they provide—regardless of the time or effort that went into creating that value—as opposed to the previous standard of fee-for-service, where they were paid based on providing a unit of service no matter how much (or little) value was created. For instance, medical services are moving away from fee-for-service payment toward value-based payment structures, such as bundled payments or the Medicare Quality Incentive Program.

Refer back to the [Value Sequence \(Module 5\)](#). Each column of the Value Sequence suggests a different way to set prices—activities would lend themselves to one pricing arrangement, results would be well suited to another, etc. Here’s a refresher on each link, and a note about how each relates to price:

- **Activities:** payment for services provided (essentially fee-for-service), such as a charging for each time a service is rendered (e.g., a flu shot) or per patient managed (e.g., a case management fee)



- **Results:** payment for specific results, such as job placement, weight loss, or reduced recidivism.
- **Impacts:** payment for changing people’s lives in material ways, such as fewer heart attacks or increased employment income for a person reentering society from prison
- **Financial value:** payment for a portion of the additional revenues, costs savings, or avoided costs. For example:
 - An assigned value per outcome, such as \$4,000 for every avoided heart attack compared to the previous measuring period
 - The Centers for Medicare and Medicaid Services’ shared savings formula for accountable care organizations

Note that the further you move across the Value Sequence, from activities and results to impacts and value creation, the complexity of the payment mechanism and level of risk increase—more measurement is needed, even perhaps to the point of requiring expensive evaluation. Assumptions multiply. Time periods stretch out. Attribution gets harder to ascertain. Getting paid is less assured.

As a rule, you should consider “expected value” when setting a price, if possible. Expected value is the payment multiplied by the probability of getting paid. Let’s say, for example, that you hope to earn at least \$200,000 to cover your costs of serving 1,000 people, with the aim of 10 pounds of weight loss per person diagnosed as pre-diabetic.

- **Activities:** You could be paid a per-person fee of \$200 for every person served regardless of weight loss; there is no risk to you because the probability of getting paid is 100%.
- **Results:** You could be paid based on how many people lose at least 10 pounds. You are at risk because payment is entirely contingent on the results you produce. Suppose the likelihood of this is 50 percent, or 500 persons with at least 10 pounds lost. To earn \$200,000, you need to charge \$400 per person who loses 10 pounds.
- **Hybrid:** You might also structure a hybrid. For example, \$100 per person served plus \$200 per result. This splits the risk between you and the payer.
- **Impacts and Value:** Maybe the payer is highly risk averse and will only consider paying for those who avoid diabetes. Your evidence shows that for every person with pre-diabetes who loses 10 pounds, 30 percent avoid diabetes within five years and that there is evidence to show that this will save \$3,000 per person in health care costs over the five years. The expected value to the payer is 150 people (500 people who lost 10+ pounds x 30 percent who avoid diabetes = 150 people) times \$3,000, which equals \$450,000. In this case, the payer has shifted all of the risk to you, so you negotiate a substantial portion of the savings—say 60 percent. Your total payment is 60 percent of \$450,000, which equals \$270,000, or \$1,800 per person who avoided diabetes ($\$270,000 \div 150 \text{ people} = \$1,800 \text{ per person}$). If your program performs well, you’ll more than cover your \$200,000 costs. But if, for example, only 100 people avoid diabetes, you’ll only earn \$180,000 and you will fail to cover your costs.

If you want to negotiate a price based on financial value, you will likely need very strong evidence that

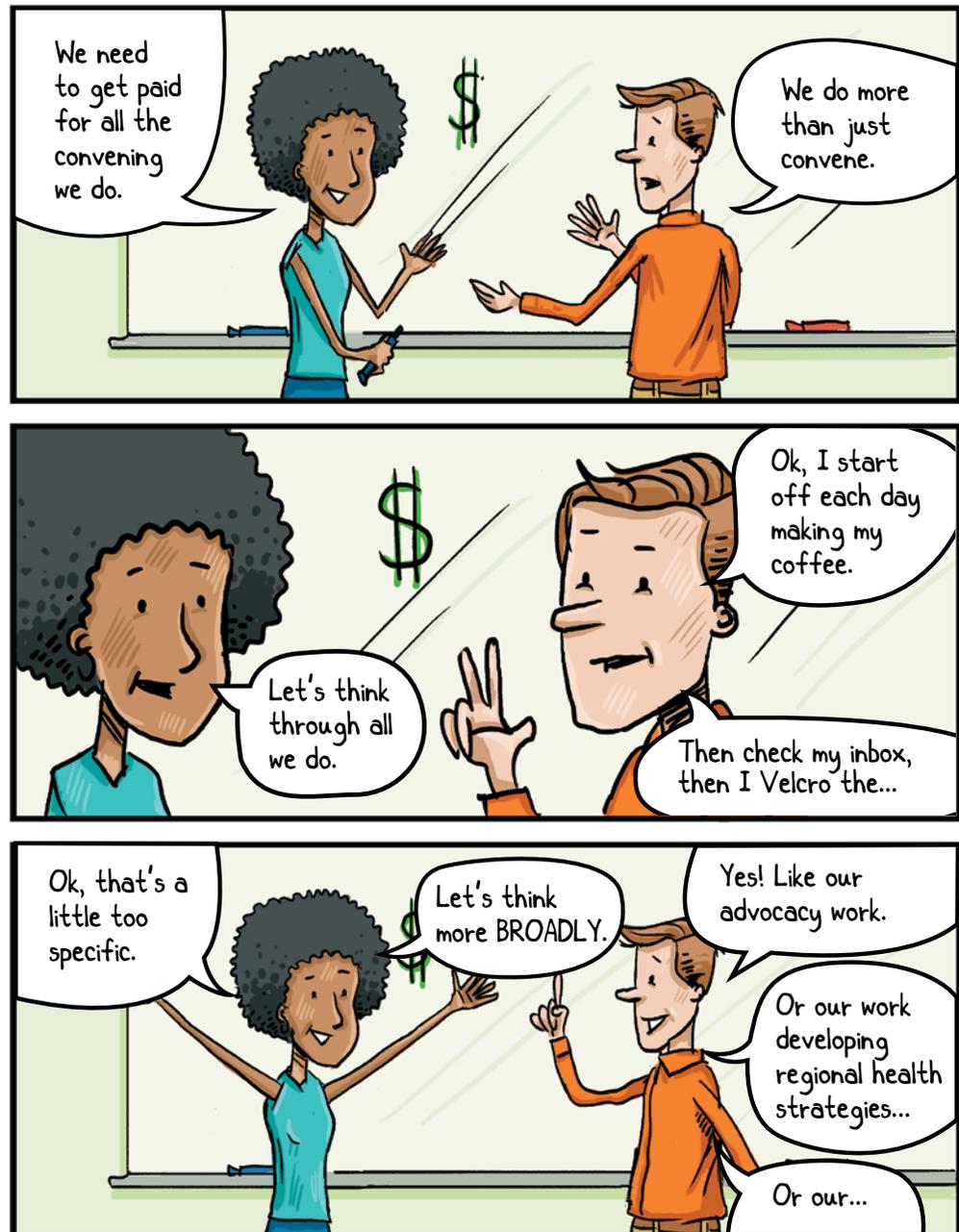
1. the result will be produced by your intervention, and
2. the result will actually produce the financial value. However, the likely ROI is only one consideration of a prospective payer; others may include:
 - You have a solid, trusting relationship with the payer.
 - You are solving a thorny problem for the payer.
 - Your product or service enhances certain reputational, political, or competitive goals the payer would like to address.

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What Integrative Activities Could You Get Paid For?

MODULE 7



“Integrative activities” used to be thought of as coordinating work done by “backbone” organizations. But many organizations share the task of governing and managing collective efforts, and these tasks can be the hardest to fund. Explore the different integrative activities and find out how other partnerships fund theirs!



What Integrative Activities Could You Get Paid For?

ReThink Health knows from its *2016 Pulse Check on Multisector Partnerships survey*¹ that you—working within a multisector partnership or organization—may come to this workbook entirely focused on funding your integrative activities. Or you might want funding of some sort, but haven't ever thought about getting paid for your integrative work, so you want to explore the idea further before jumping too deeply into the workbook. This is a special concern, so we built this module to help you identify which activities you conduct (or might want to in the future). Once you're more certain of your activities, you can then use other modules in the workbook to identify the value you create and how to put a price tag on that value (start this work at [Module 6](#)). To provide a little inspiration, we've also included detailed briefs describing how multisector partnerships from around the country get paid for their integrative activities (the briefs are located below the worksheet, beginning on page 15).

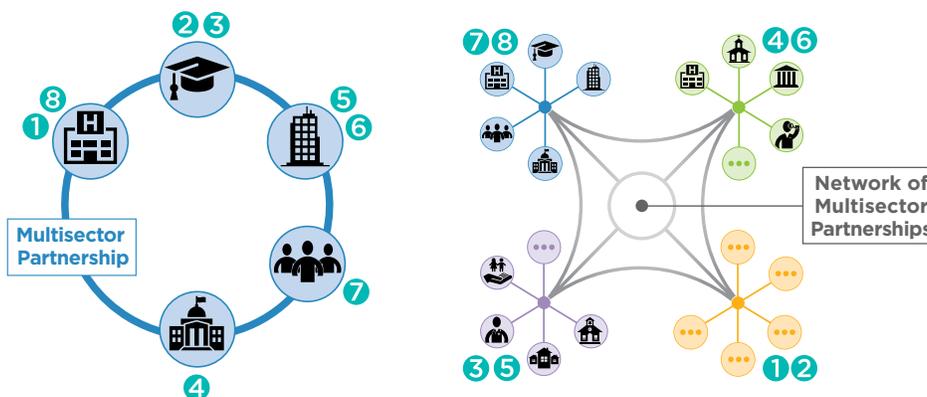
If you are unfamiliar with integrative activities, [Appendix 1](#) describes the eight activities ReThink Health has identified in detail (and we provided even more information on the concept on page 8 of the [Introduction](#)). In short, they are:

1. Convening stakeholders for cross-sector collaboration and information sharing
2. Analyzing and planning for regional health improvement
3. Designing ongoing infrastructure and governance
4. Implementing strategy and managing performance of region-wide efforts
5. Catalyzing innovation and design
6. Designing financing structure and strategy
7. Advocating for public policy
8. Monitoring, measuring, and evaluating region-wide efforts

ReThink Health has learned it is uncommon for all of these integrative activities to be handled by any one partnership or organization (although it does happen sometimes). More typically—and often more effectively—they are distributed among all the partnerships and organizations working together to transform health in the region. So, even if you're only doing one of these activities, you are in good company. What's important for the region's success (when partners' shared purpose is to transform health) is that all of the activities are done well.

Distributing Integrative Activities Among Stakeholders

Each circled number corresponds to an integrative activity from the list above.



¹ <https://www.rethinkhealth.org/tools/pulse-check/>



Two Tips For Your Sanity: Focus On the *Who* and the *What*

We have two tips, based on our experiences when testing the worksheet below. First, *you must identify which multisector partnership or organization you have in mind for the purposes of this exercise*. This exercise will likely be frustrating if you try to complete it while wearing hats for multiple organizations. You might have to remind others doing this module with you of that intention.

Second, don't confuse current work with future work (work that is just an idea for "someday" or still in the planning stages). You can do any of the worksheets in this workbook considering either current or future work, but don't try to do both at the same time. It becomes quite confusing, and you will not get the outcomes you need.



WORKSHEET

What Integrative Activities Could You Get Paid For?

OBJECTIVE: To identify the integrative activities you conduct, so you can figure out (using exercises in other modules) how to get paid for them.

TIME: 60-90 minutes (depending on size of group)

MATERIALS:

- Copies of this module (including briefs), this worksheet, and [Appendix 1](#) for everyone in the group
- Flip charts
- Markers

PARTICIPANTS: Two-to-five people most familiar with your integrative activities; could include a mix of an executive team, staff, finance committee, and board members of your multisector partnership or organization.

STEP 1

Provide each participant with a copy of the module (pages 1 and 2), this worksheet, the briefs below (pages 15 – 27), and [Appendix 1](#). Provide time for participants to independently review the definitions and examples associated with each integrative activity on pages 5 – 14. For each activity there is a set of reflection questions to help you determine if your partnership or organization conducts the activity. Participants should take time to answer the questions independently.

STEP 2

As a group, go through each of the eight integrative activities and briefly discuss your answers to check for alignment. Quickly analyze whether the group is in agreement about the activities your partnership conducts, or if there is some variance or disagreement. If the former, agree on short phrases or sentences for each integrative activity conducted (include the specific functions and deliverables the group identified). This will confirm you have alignment and help shape future work. (See the examples provided on pages 5 – 14; specifically the sentences under “Specific function(s).”)

If there are differing ideas about your partnership’s integrative activities, the following steps might help to generate some alignment:

1. Share ideas about any key services or deliverables your partnership provides and how they relate to the eight integrative activities. Give each participant three-to-five minutes to share their ideas; write and post each one on separate flip chart pages. If there are similar ideas, make a tally mark on each flip chart—and note any small distinctions—to reflect how many people brought similar ideas to the table. Once everyone has shared their ideas, gauge the degree of alignment that exists for each idea by reviewing the flip chart notes. Hopefully, you’ll notice that there are a few standout activities that everyone is in agreement on.
2. If necessary, briefly discuss the standouts. Take the temperature of the room. If you sense there is more discussion needed in order to reach consensus around which integrative activities your partnership conducts, take the time to have the discussion.
3. Agree on the integrative activities your partnership conducts. Then generate short phrases or sentences that describe the specific functions (what you do) and deliverables (what it produces) associated with each.



BEYOND THE Grant TIP

It’s possible to prepare for this meeting by asking group members to come prepared with Step 1 completed as well as draft sentences for the “yes” boxes they checked. Then the group can jump right in to Step 2 discussions to make the most of your time.



STEP 3

Determine the integrative activities for which your partnership will seek payment. Now, go back to [Module 5](#) and step through the Value Sequence to outline the value those integrative activities create. If you want help putting a price tag on the activities' value, [Module 6](#) can help.



What integrative activities do we conduct that we could get paid for?

1 INTEGRATIVE ACTIVITY **Convening Stakeholders for Cross-sector Collaboration and Information Sharing**

Do you conduct any of the following specific functions?

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Engage stakeholders or multisector partnerships 2. Build public will 3. Enroll others in advocacy via convening/organizing 4. Determine agenda | <ol style="list-style-type: none"> 5. Facilitate connections and one-to-ones among key leaders 6. Provide communications support, including partnering with conveners to build public will (e.g., website, newsletters, outreach) 7. Manage meeting logistics 8. Create detailed meeting design, including preparation and follow-up |
|--|--|

Example (see brief on page 23 and 24)

Name of multisector partnership or organization	Specific function(s)
Michigan Health Improvement Alliance (MiHIA)	Neutral convener to bring about stakeholders' information sharing and cross-sector collaboration
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
Stakeholders want a voice in determining the agenda, which resources will be pursued (and how), and access to any resources leveraged.	Stakeholders pay via direct payment to MiHIA or make donations to its affiliate organization.

1 | Do you conduct this integrative activity for regional partners? YES NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?

What integrative activities do we conduct that we could get paid for?

2

INTEGRATIVE ACTIVITY

Analyzing and Planning for Regional Health Improvement

Do you conduct any of the following specific functions?

- | | |
|---|--|
| <ol style="list-style-type: none"> 1. Lead the setting of collective vision and goals; ensure resident involvement in the process 2. Devise shared strategy among stakeholders 3. Identify critical strategic questions, including differences in interests of stakeholders 4. Secure commitments to implement strategy | <ol style="list-style-type: none"> 5. Advocate daily for goals and strategy (internal and external) 6. Facilitate strategy development process, including conducting of needs assessment 7. Serve as a neutral data synthesizer |
|---|--|

Example A (see brief on page 15–18)

Name of multisector partnership or organization	Specific function(s)
Central Oregon Health Council (COHC)	The COHC staff acts as a neutral convener to facilitate the COHC board's work to reach consensus around a state-required Regional Health Improvement Plan (RHIP).
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
(1) COHC board members want to co-create the plan for achieving their collective goal of better coordinating care for the Medicaid population in the region, to make sure their organizational interests are represented. They want to do this without having to become experts in coordination, and without having to step out of their own organizational roles when they come to the table. (2) Working with COHC, the local Medicaid Coordinated Care Organization (CCO) gets to show it is reinvesting savings, informed by the public. This might help the CCO hold on to their state contract with Medicaid—especially since the state seems to look favorably on this model.	The CCO pays, according to a Joint Management Agreement (JMA) formed with COHC. The JMA specifies that whatever payment the Medicaid CCO takes in from the state, per member per month, 0.325 percent (or 3/10 of 1 percent of its total revenue from the state) percent is paid to COHC to be used for operating costs (mostly, to ensure creation and implementation of the RHIP). The JMA also caps the Medicaid CCO's profit at 2 percent and provides that any additional profit must be paid to COHC for reinvestment into the RHIP (this additional profit is called "shared savings.") In order to be able to establish this agreement, the COHC board pursued a state law that would make them governing body of the CCO.

Example B (see brief on page 19–22)

Name of multisector partnership or organization	Specific function(s)
Greater Fall River Partners for a Healthier Community (GFR Partners)	Neutral convener of a coalition of 25 member organizations that collaboratively plan prevention strategies for benefit of the community overall.
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
The Commonwealth of Massachusetts is interested in communities like Greater Fall River having a plan to maximize value from lean investments in prevention, through collaborative coalitions [in 27 Community Health Network Areas (CHNAs)] that identify and address specific community needs. Stakeholders work to achieve regional health improvement through multi-agency projects (stakeholders raise project funds together), and projects run by individual organizations (that raise their own project funds). Having a plan brings more grants into the community, helping stakeholders to—through all of their various efforts—realize the common goals the plan lays out and get increased investment in their own work.	The Commonwealth of Massachusetts pays, through a Determination of Need regulation that provides dedicated funding from hospital construction projects (5 percent of each project) to CHNAs for the purpose of bringing community expertise into regional strategy development around prevention.



What integrative activities do we conduct that we could get paid for?

2

INTEGRATIVE ACTIVITY

CONTINUED

Analyzing and Planning for Regional Health Improvement

- 1 | Do you conduct this integrative activity for regional partners? YES NO

- 2 | What specific functions do you conduct?

- 3 | What specific deliverables do you provide when you conduct those functions?

- 4 | How do other organizations providing similar functions in your region collaborate or compete with you?



3

INTEGRATIVE ACTIVITY

Designing Ongoing Infrastructure and Governance

Do you conduct any of the following specific functions?

- | | |
|---|--|
| 1. Design and ratify shared governance structure as well as composition and decision-making rules | 4. Provide facilitation for interim governance bodies to design governance changes over time |
| 2. Provide strategic oversight of infrastructure and governance | 5. Manage recruitment, elections, and transitions in membership of governance bodies |
| 3. Build relationships with other oversight groups | 6. Facilitate communications among oversight groups |

1 | Do you conduct this integrative activity for regional partners? YES NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?



4

INTEGRATIVE ACTIVITY

Implementing Strategy; Managing Performance of Region-Wide Efforts

Do you conduct any of the following specific functions?

- | | |
|--|--|
| 1. Strategic oversight of actual implementation; ensure accountability and effectiveness | 3. Direct and/or manage projects, which might be about supporting work groups or alignment of activities |
| 2. Celebrate successes; share learnings | 4. Support stakeholders' abilities to work within the partnership (e.g., use the partnerships' systems for sharing data) |

Example (see brief on page 15-18)

Name of multisector partnership or organization	Specific function(s)
Central Oregon Health Council (COHC)	The COHC staff coordinates accomplishment of the RHIP, within the context of the shared purpose established by the COHC board.
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
(1) COHC board members are interested in implementing the RHIP, and taking on specific aspects of the work, but no one stakeholder could take on the integrative activity itself and still represent its own interests. (2) Working with COHC, the local Medicaid Coordinated Care Organization (CCO) gets to show it is reinvesting savings, informed by the public. This might help the CCO hold on to their state contract with Medicaid—especially since the state seems to look favorably on this model.	The CCO pays, according to a Joint Management Agreement (JMA) formed with COHC. The JMA specifies that whatever payment the Medicaid CCO takes in from the state, per member per month, 0.325 percent (or 3/10 of 1 percent of its total revenue from the state) percent is paid to COHC to be used for operating costs (mostly, to ensure creation and implementation of the RHIP). The JMA also caps the Medicaid CCO's profit at 2 percent and provides that any additional profit must be paid to COHC for reinvestment into the RHIP (this additional profit is called "shared savings.") In order to be able to establish this agreement, the COHC board pursued a state law that would make them governing body of the CCO.

1 | Do you conduct this integrative activity for regional partners? YES NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?



5

INTEGRATIVE ACTIVITY

Catalyzing Innovation and Redesign

Do you conduct any of the following specific functions?

- | | |
|-------------------------------------|--|
| 1. Set audacious goals | 5. Build human capacity to generate and test innovations |
| 2. Lead learning activities | 6. Conduct and synthesize research |
| 3. Create conditions for innovation | 7. Facilitate networking |
| 4. Provide seed capital | 8. Manage process of identifying innovations to pursue |

1 | Do you conduct this integrative activity for regional partners? YES NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?



6

INTEGRATIVE ACTIVITY

Designing Financing Structure and Strategy

Do you conduct any of the following specific functions?

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Determine financing vision and strategic priorities 2. Create governance structure for funding decisions and accountability management 3. Determine financing structure for integrative activities 4. Mobilize funding to implement priorities and initiatives 5. Research possible structures and provide design support <ol style="list-style-type: none"> a. Develop charitable giving strategy b. Write grants | <ol style="list-style-type: none"> 6. Administer grants, which might include acting as fiscal agent 7. Host innovation fund <ol style="list-style-type: none"> a. Receive and review applications b. Provide recommendations to governance body c. Act as fiscal agent for funds to be redistributed 8. Provide staff support for governance of financing |
|--|--|

Example (see brief on page 15-18)

Name of multisector partnership or organization	Specific function(s)
Central Oregon Health Council (COHC)	COHC staff monitors, measures, and evaluates the grants/investments COHC makes in organizations throughout the community, checking for the organizations' adherence to their proposals and informing wise investment strategy.
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
(1) COHC board members (who are the stakeholders) do not have the bandwidth to carry out this work, and want to be in more of a broad, oversight position in reviewing whether COHC is making the wisest investments to realize the goals of the Regional Health Improvement Plan. (2) Working with COHC, the local Medicaid Coordinated Care Organization (CCO) gets to show it is reinvesting savings, informed by the public. This might help the CCO hold on to their state contract with Medicaid—especially since the state seems to look favorably on this model.	The CCO pays, according to a Joint Management Agreement (JMA) formed with COHC. The JMA specifies that whatever payment the Medicaid CCO takes in from the state, per member per month, 0.325 percent (or 3/10 of 1 percent of its total revenue from the state) percent is paid to COHC to be used for operating costs (mostly, to ensure creation and implementation of the RHIP). The JMA also caps the Medicaid CCO's profit at 2 percent and provides that any additional profit must be paid to COHC for reinvestment into the RHIP (this additional profit is called "shared savings.") In order to be able to establish this agreement, the COHC board pursued a state law that would make them governing body of the CCO.

1 | Do you conduct this integrative activity for regional partners? YES NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?



7

INTEGRATIVE ACTIVITY Advocating for Public Policy

Do you conduct any of the following specific functions?

- | | |
|---|---|
| 1. Set policy priorities | 3. Communicate impact of policies |
| 2. Build relationships with thought leaders and policy makers | 4. Implement through influence campaigns and more |

1 | Do you conduct this integrative activity for regional partners? YES NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?

8

INTEGRATIVE ACTIVITY

Monitoring, Measuring, and Evaluating Region-wide Efforts

Do you conduct any of the following specific functions?

- | | |
|---|---|
| 1. Provide strategic guidance and oversight of overall information system | 4. Design and facilitate learning and improvement process |
| 2. Review results and modify action plans | 5. Monitor progress toward shared goals |
| 3. Envision and develop process for sharing results with residents | 6. Design and facilitate forums for accountability to residents |

Example A (see brief on page 25–27)

Name of multisector partnership or organization	Specific function(s)
Trenton Health Team (THT)	THT works with its partner members to design and run regional performance monitoring efforts, using a regional health information exchange (HIE).
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
Now, with one system of aggregated data, THT and others can “watch” how patients move through the community in a way that is timelier and more cost efficient than ever before. THT also provides consulting to partners who want to use the HIE. This allows partners to incorporate the technology into the work they do every day.	THT receives unrestricted revenue from annual HIE membership fees paid by health practitioners who so they have real time access integrated and holistic patient records that support treatment decisions and strategies.

Example B (see brief on page 15–18)

Name of multisector partnership or organization	Specific function(s)
Central Oregon Health Council (COHC)	COHC staff monitors, measures, and evaluates the grants/investments COHC makes in organizations throughout the community, checking for the organizations’ adherence to their proposals and informing wise investment strategy.
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
(1) COHC board members (who are the stakeholders) do not have the bandwidth to carry out this work, and want to be in more of a broad, oversight position in reviewing whether COHC is making the wisest investments to realize the goals of the Regional Health Improvement Plan. (2) Working with COHC, the local Medicaid Coordinated Care Organization (CCO) gets to show it is reinvesting savings, informed by the public. This might help the CCO hold on to their state contract with Medicaid—especially since the state seems to look favorably on this model.	The CCO pays, according to a Joint Management Agreement (JMA) formed with COHC. The JMA specifies that whatever payment the Medicaid CCO takes in from the state, per member per month, 0.325 percent (or 3/10 of 1 percent of its total revenue from the state) percent is paid to COHC to be used for operating costs (mostly, to ensure creation and implementation of the RHIP). The JMA also caps the Medicaid CCO’s profit at 2 percent and provides that any additional profit must be paid to COHC for reinvestment into the RHIP (this additional profit is called “shared savings.”) In order to be able to establish this agreement, the COHC board pursued a state law that would make them governing body of the CCO.



8

INTEGRATIVE ACTIVITY

CONTINUED

Monitoring, Measuring, and Evaluating Region-wide Efforts

- 1 | Do you conduct this integrative activity for regional partners? YES NO

- 2 | What specific functions do you conduct?

- 3 | What specific deliverables do you provide when you conduct those functions?

- 4 | How do other organizations providing similar functions in your region collaborate or compete with you?



BRIEFS

Some Multisector Partnerships Already Get Paid for Their Integrative Activities

Central Oregon Health Council (COHC)²

WEBSITE: COHealthCouncil.org

Integrative Activities COHC Gets Paid For:

- **Analyzing and planning for regional health improvement.** COHC staff acts as a neutral convener to facilitate COHC board's work to reach consensus around a state-required Regional Health Improvement Plan (RHIP).
- **Implementing strategy and managing performance of region-wide effort.** COHC staff coordinates implementation of the RHIP, within the context of the shared purpose established by COHC board.
- **Designing financing structure and strategy.** COHC staff supports COHC board review and approval of proposals from organizations throughout the community that seek grants to help address RHIP goals. COHC allocates grants from funds that are generated through a joint management agreement (JMA) with PacificSource, a Medicaid coordinated care organization (CCO). The CCO's profit is capped at two percent; the JMA provides any profit over two percent to COHC for reinvestment into the RHIP—creating a shared savings arrangement. Recently, the staff has been working with the board to co-create a process that allows staff to take on more of the review and approval process.
- **Monitoring, measuring, and evaluating region-wide efforts.** COHC staff monitors, measures, and evaluates the grants/investments COHC makes to organizations throughout the community. COHC learns from its successes and mistakes, and uses results to inform its future investment strategies.

State of Oregon Establishes COHC to Plan for Regional Health Improvement, but There's No Funding for Implementation

When a local man with severe and persistent mental illness was found dead on the street in 2011, community members knew they had to do better for the region's Medicaid population. This devastating event immediately created a shared value among major health organizations in the community to work together, but they needed a coordinating organization. Bruce Goldberg, who was the state director of Medicaid at the time, heard the community's desire to approach health care differently in Central Oregon, and asked if some influential leaders would be willing to be part of a multisector partnership to better address the health needs of Medicaid patients. They said yes. "Central Oregon is kind of an odd duck," said Donna Mills, director of COHC. "If we believe in something, we will work relentlessly to get it done."

That same year, as a result of Goldberg's efforts, the State of Oregon passed Senate Bill 204 to create the Central Oregon Health Council (COHC) as the community group that would be required to develop and manage a Regional Health Improvement Plan (RHIP), informed by a regional health assessment. COHC became a 501(c)3 and passed bylaws, a step encouraged in the authorizing legislation. The bylaws stipulate that no more than 14 members (from specific sectors influencing health) will have voting power in determining the RHIP's scope of the activities and services.

² Donna Mills, interview by Kim Farris-Berg, February 13, 2017.



Today, these members comprise the board of directors of COHC. Each member of the board must have the authority to make the ultimate decisions on behalf of their organizations and have influence in the community—delegates and proxies are not permitted. Members include the senior vice president of PacificSource (the local CCO that works with the state to provide health services for those enrolled in the Oregon Health Plan), the CEO of the local hospital, the president and founder of the dental care organization (DCO), the superintendent of High Desert Education Services District and Long Term Service Supports, the county commissioners (from each of the three counties served), a leader of behavioral health delivery, the leader from the federally qualified health center, and citizen representatives.

As the members began to plan their first RHIP, it quickly became clear that hiring staff for COHC would be of great value to its board members (and ultimately the community) for one main reason: the staff's ability to serve as a neutral convener. "Negotiating an RHIP with all COHC members, each coming to the table with different perspectives and priorities, is difficult. But our work would be impossible if they did not feel safe and respected in bringing their own perspectives to the table," said Mills. With COHC staff at the center of the work, all the members can help realize the common purpose of better coordinating care for the region's Medicaid population without each board member having to become an expert in coordinating the region's health care, and without having to step out of their own organizational role when they come to the table.

Mills explained, "COHC staff's work is of value to our board members because *they* get to keep being the experts in what they do; they don't have to come here and be the 'jack of all trades and master of none' when it comes to cross-community coordination. I don't wear all of their hats, I just wear COHC's. My role is to be neutral, so each member of the community can do its best work to help co-create our RHIP. In this way, we end up with an RHIP that is rooted in all of their expertise. I have their trust, which puts me in a place to expose and blend the opportunities each of them offers. And we are very transparent. Sometimes members of the finance committee question a line item in our budget. To that I reply, 'Let's talk about it. We need to make sure it's right, and that everyone who wants to learn understands what's going on.'"

With COHC staff at the center of the work, all the members can help realize the common purpose of better coordinating care for the region's Medicaid population without having to become experts in coordination, and without having to step out of their own organizational role when they come to the table.

In its early years, COHC worked hard at establishing a high-performing, collaborative culture, which led to the co-creation of a highly valued RHIP. But implementing the RHIP proved next to impossible without any significant funding—a factor not provided for in legislation (other than the ability to enter into contracts and receive grants). So the board began raising the question: how would it fund the work of the RHIP and the work COHC staff does to coordinate accomplishment of the RHIP?

COHC Determines the Medicaid CCO Will Pay for COHC's Coordination, and Potentially the Work of the RHIP

After what Mills described as a long period of "disagreements and gnashing of teeth" about where sustainable financing ought to come from, COHC board decided to pursue state legislation that would formally make COHC the governing body of PacificSource, the Medicaid CCO. COHC board's intent was to secure formal authority for COHC to enter into a JMA with PacificSource. A JMA would allow them to ensure that the CCO would pay to cover the costs of COHC's operating budget and potentially pay for the work required to carry out the RHIP. A new Senate Bill 648 was passed for this purpose in 2015.

With legislation in hand, the board could work with a team of lawyers to establish the terms of agreement between COHC and PacificSource. The terms were agreed on as follows: whatever payment PacificSource takes in from the state, per member per month, 0.325 percent (or 3/10 of 1 percent of its total revenue from the state) is paid to COHC to be used for operating costs. There is also a secondary stream of funding embedded into the agreement, called "shared savings," which caps PacificSource's profit at two percent and provides that any additional profit must be paid to COHC for reinvestment into the RHIP. (No one ever expected this to be used, but Medicaid expansion created an influx of unexpected funding.)



When asked why PacificSource is willing to pay, Mills speculated, “If there is additional profit and it goes to COHC, even if we hold it for a bit, the public sees it as money reinvested in the community. If PacificSource hangs on to any additional profit, they are seen as withholding it from the community, even if they plan to hand it over when needed. In this arrangement, PacificSource gets to create a different image. They can show they are working with COHC to ensure reinvestment of savings, and that the public informs the reinvestment strategy. This could potentially help them hold on to their state contract with Medicaid—especially since no other CCO is doing this and the state looks favorably on this model.”

In 2014, 2015, and 2016, due to uncertainties about Medicaid expansion, Oregon overestimated the pent-up demand for health care services Medicaid recipients might use. PacificSource paid COHC \$17 million in shared savings. COHC immediately called for community members to submit proposals that aligned with the RHIP, and formed a special committee to review and approve them. As of 2018, \$9 million has been reinvested in the community.

Until recently, COHC board has had a significant role in reviewing and approving any proposals over \$150,000, but this has made the approval process unintentionally cumbersome. COHC staff is now working with the board to co-create a process that will allow the staff to take on more of that role in a way that continues to consider the board’s shared purpose (mission, vision, values, and goals established in the RHIP). COHC recently hired a data analyst to assist in ensuring adequate measurement and oversight of their investments.

A positive side benefit of receiving the \$17 million has been that the broader community is increasingly attracted to getting involved with COHC, which has allowed two important things: (1) internally, the staff has been able to open important conversations with the board about widening its circle of members; and (2) externally, COHC has been able to demonstrate just how well the concept of organizations like COHC can work on behalf of the community.

Mills said, “It makes sense that more people want to join us! We’ve got money, and they would like some of it. We say, ‘If you start participating, you will have a voice! And our current board and staff will understand more about what you do, so you’ll have a better chance of your proposal being understood and approved.’ We also know that, when they see what’s happening at the table, they’ll understand better where the money is going and why, and they’ll come to appreciate why our standards for approval are so high.”

What’s Next?

There are 16 other CCOs operating in communities across Oregon, but only two regions have the business model that COHC does with PacificSource (the other is a similar community group in another region). And in most communities, even planning the RHIP is the job of public health professionals. The COHC-PacificSource arrangement was considered somewhat of an experiment, so the legislation is scheduled to sunset in 2022. COHC is advocating for an extension, and Mills reports that the state of Oregon is interested in encouraging similar models in the next iteration of its CCO legislation. Some policy makers are already informally talking about creating “CCO 2.0.”

But if that is not to be, it’s important to understand that Senate Bill 204 would still exist—so COHC would continue to exist, and would need to find other means of sustainable financing. In fact, COHC is well aware that it should also be prepared for lesser amount of shared savings under the current arrangement, which would happen if the Oregon Health Authority were to impact the CCO’s profit margin by reducing the Medicaid reimbursement rates. As a precaution, COHC planned a five-year budget as if no additional shared savings would be available to it in future years. And COHC has invested some of the shared savings already earned, for the long-term interest of the community.

COHC believes that its regional presence—its understanding of the local players and how to make things happen in the region—could attract funding, especially as the state and other groups seek COHC’s expertise in making programs work. Some possibilities for funding include:

- All of the board members could make a financial contribution relative to the value they receive from COHC.
- COHC could be a fiscal agent (i.e., performing financial duties on another organization’s behalf) for organizations that need such a service within the region.

- 
- COHC could secure arrangements similar to the one it has with PacificSource with other payers (perhaps as part of their community benefit spending), given that the population health work COHC does has benefits beyond the Medicaid population.
 - COHC could pursue large grants.

What Are the Challenges?

- *COHC staff must be widely trusted in order to maintain effectiveness as a neutral convener.* Being perceived as friendly, open, and trustworthy to all stakeholders is the key to effectiveness, and requires the staff to have very specific interpersonal skills.
- *If the shared savings weren't going to COHC, PacificSource would probably keep it.* COHC must consistently demonstrate its value to PacificSource and other stakeholders.
- *There are a lot of unknowns.* Will the Senate Bill 648 arrangement extend past its current planned sunset in 2022? How much will shared savings vary from year to year? Will smaller CCOs, like PacificSource, even be able to stay in business as rates are cut and if Medicaid populations are reduced? It's hard to make predictions about what's ahead in this environment, and working to open other lines of business "just in case" while preserving current funding sources is a lot of work.

Resources:

[Oregon Senate Bill 648, 2015³](https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB648/Introduced) : Established COHC as the governing body for the CCO (so it could enter into formal agreements to receive funding from the CCO).

[Oregon Senate Bill 204, 2011, Sections 13-18⁴](https://olis.leg.state.or.us/liz/2011R1/Downloads/MeasureDocument/SB204) : Established COHC as a community group that would be required to develop the Regional Health Improvement Plan (RHIP).

³ <https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB648/Introduced>

⁴ <https://olis.leg.state.or.us/liz/2011R1/Downloads/MeasureDocument/SB204>



Greater Fall River Partners for a Healthier Community (GFR Partners)

WEBSITE: GFRpartners.com

Integrative Activities GFR Partners Gets Paid For:

- **Analyzing and planning for regional health improvement.** Neutral convener of a coalition of 25 member organizations that collaboratively plan prevention strategies for benefit of the community.
- **Designing financing structure and strategy.** Helps small groups of stakeholders work together to secure large grants for projects that will improve prevention in the region.

Commonwealth of Massachusetts Amends the Determination of Need Regulation to Provide Dedicated Funding for 27 Community Health Network Areas

In the early 1990s, Dave Mulligan, a visionary commissioner of the Massachusetts Department of Public Health (DPH), advanced a message that health is not created by hospitals, where people go when they already have diseases, but is instead a function of community health prevention efforts. He asserted that hospitals have a responsibility to help support prevention work in the communities, and that the community itself ought to have the lead role in determining how the prevention money is best spent for its specific population and context. This can be particularly important in Massachusetts where there's a perception that state-level decisions are sometimes the result of Boston-centric thinking (other parts of the state have very different needs).

Acting on this vision, Mulligan helped enact amendments to the Determination of Need (DoN) statute that divided the state into 27 Community Health Network Areas (CHNAs), each with the purpose of bringing community expertise into regional strategy development around prevention. To fund each CHNA, hospitals within each of the 27 geographic boundaries must dedicate five percent of any hospital construction project costs (which must be approved by DPH) to prevention work in their respective boundary. The hospitals make payments to their local CHNA over five years. Currently, all the Massachusetts CHNAs together are receiving about \$107 million from construction projects.

In Boston, there are 17 hospitals whose projects fund one CHNA and that CHNA, therefore, has millions of dollars to work with. The Greater Fall River area, by contrast, has two hospitals, and both have provided funding to the area's CHNA, the Greater Fall River Partners (GFR Partners), as part of their hospital construction budgets. The last project resulted in \$215,000 of unrestricted funding per year for five years. There have been other projects with other amounts, and the projects sometimes overlap so there are multiple income streams at once. The stakeholders involved with GFR Partners feel a sense of responsibility to use those funds to cover the costs of something the 15-25 community partners on the steering committee value—GFR Partners' role as a neutral convener leading the partners through collaborative analysis and planning for what's needed to achieve regional health improvement.

The Commonwealth and Its Communities Are Getting Plenty of Value from State Investment

The purpose of the Commonwealth's investment is to bring community expertise into regional strategy development around prevention. This is happening in the Greater Fall River area in at least three ways:

⁵ David Weed and Wendy Garf-Lipp, interview by Kim Farris-Berg, October 26, 2016.



First, GFR Partners has established a coalition of 25 member organizations that take ownership of collaboratively-developed prevention efforts, for benefit of the community overall. Every member organization has representation on the GFR Partners' steering committee, which has cultivated high levels of collaboration in setting and accomplishing a shared set of goals and objectives. Partners recognize that collaboration brings more grants (and potentially other funding) to the community and this leads each organization to bring many funding opportunities to the full table so partners can work together to decide who is best positioned to be the lead agency.

"None of our community problems can be solved by any one agency," said GFR Partners Secretary Wendy Garf-Lipp. "We have to apply a holistic approach." For example, multiple organizations are involved in youth prevention work—sometimes working collaboratively with a multi-agency grant and sometimes raising their own project funds for organization-specific goals that align with the GFR Partners' larger goals. This collaborative strategy led to a 37 percent reduction in youth violence over its first two years.

"As a nation we've done so much R&D. What we don't have is a way to implement what we we've learned at the community level, unless funding is built into the system like it is here in Massachusetts."

- Dr. David Weed

Dr. David Weed, a former GFR Partners executive director, said, "Dedicated state funding results in a feeling of shared, local ownership. GFR Partners has been here for 25 years now, with a sustainable funding source. People know us, they are part of us, they vote on these collaborative goals! Because the state makes it a priority to make this substantial investment at the community level, we all feel it is our responsibility to make the funding really work for our community. This is so important because at this time there are a thousand demonstrations of what works—as a nation we've done so much R&D. What many communities don't have is a way to implement at the community level, unless funding is built into the system like it is here in Massachusetts."

Second, GFR Partners has figured out ways to improve the community from the inside out, in partnership with stakeholders. There is no official building or office for the GFR Partners, a 501(c)3 in which everyone works remotely. All of GFR Partners' employees, two full-time and three part-time staff, are funded through the DoN funding, and are housed throughout the community. The GFR Partners' steering committee has found that working to establish a strong presence in the right places allows stakeholders to work from the inside out to more swiftly realize community goals. For example, a GFR employee who was placed in the education department was instrumental in leveraging her relationships inside her organization to uncover the need for a department head for physical education in order to achieve community goals. As a result, GFR Partners funded a new "head of physical education" position, which has been critical to increasing the commitment to physical education inside Greater Fall River schools.

GFR Partners points out that this is a far better investment of state money than the more typical top-down mandates, which are not only costly to administer, but which often get limited support at the community-level. "There are hundreds of millions of dollars going through this community in all aspects, and we are coordinating a lot of that with just \$215,000 a year. Why can't this exist in every community in America?" asked Weed. Garf-Lipp added, "Our mantra is the community will tell us what it really needs. This work has far more impact than what results when communities are only responsible for carrying out top-down mandates from state and federal officials who don't know what's happening at the local level."

Third, GFR Partners knows its local stakeholders (and their regional plan) well enough to help them respond quickly to opportunities to secure additional funding for projects that will increase prevention in the region. GFR Partners helps members of their partnership realize community priorities by:

- monitoring and identifying the right opportunities;
- perpetually helping stakeholders form strong relationships and common goals with each other, which make quick commitment to large, collaborative projects easier;
- bringing the right collaborators to a project by being aware of stakeholders' strengths and capacities;
- working together with collaborators to determine which organization is best equipped to be the lead agency to pursue a given opportunity; and
- working with the lead agency to bring all the pieces together to author and secure large grants on behalf of the group.



What Are the Challenges?

- *Basing DoN funding on geography has yielded imbalanced results across CHNAs.* Hospital construction happens more in urban areas than in rural ones, so a handful of the original 27 CHNAs are now defunct (they never had a sustainable source of revenue), and seven or eight are really struggling due to limited funding. That said, GFR Partners estimates that there are 10-12 CHNAs that are incredibly high functioning and several more that are high functioning.

Discussion is underway about ways to potentially modify this process to be more geographically inclusive, and help more CHNAs get to this level of function. One idea on the table is to put all the money from various hospitals into a single pot, and redistribute by population numbers. Another idea is to place CHNA's geographic boundaries around populations of 150,000.

- *High-functioning CHNAs need to prepare themselves for the possibility that no new construction will occur, and their funding streams will run dry.* This is true for all CHNAs, but is currently a real possibility in Greater Fall River. With its two hospitals in litigation over which will provide a particular service, and construction projects on hold, GFR Partners' funding stream could dry up in 2020. The CHNA is not taking any chances and is broadening its financial plan in case an alternate strategy is needed.
- *CHNAs need to fully understand the DoN regulation so they are prepared when challenged about what, exactly, it authorizes.* One hospital some time ago, for example, told GFR Partners that the DoN regulation specifies the CHNA must spend most of the funds on direct mental health services. But GFR Partners was well-versed in the regulation and pushed back, emphasizing that its purpose is not to provide direct service, and explaining that the community did not identify mental health as a top priority. Had GFR Partners not been so well-versed, it wouldn't have been so easily able to hold its ground.

Resources:

[Determination of Need Factor 9, Community Health Initiatives, Policies and Procedures](http://www.mass.gov/eohhs/docs/dph/quality/don/don-community-health-initiatives.pdf)⁶

Overview of the DoN regulation (105 CMR 100.000), established by Commonwealth of Massachusetts to promote the availability and accessibility of cost-effective, quality health care services to citizens and assist in controlling health care costs

[Determination of Need Regulation \(105 CMR 100.000\)](http://www.mass.gov/eohhs/docs/dph/regs/105cmr100.pdf)⁷

Regulation language

⁶ <http://www.mass.gov/eohhs/docs/dph/quality/don/don-community-health-initiatives.pdf>

⁷ <http://www.mass.gov/eohhs/docs/dph/regs/105cmr100.pdf>



“

If these opportunities were pursued by whoever felt like applying, our community would hardly ever see these major grants, I often go to our members and say, ‘Here’s a great opportunity. Let’s see what we can partner up on and pull together.’ GFR Partners has built up enough trust that now our stakeholders bring the opportunities to us to help them find the right team. Our stakeholders have learned that closed-doors are destructive to the community process.

- Dr. David Weed, former GFR Partners Executive Director



Michigan Health Improvement Alliance, Inc. (MiHIA)⁸

WEBSITE: MiHIA.org

Integrative Activities MiHIA Gets Paid For:

- **Convening stakeholders for cross-sector collaboration and information sharing.** Neutral convener to bring about information sharing and cross-sector collaboration among multisector partnership stakeholders.

MiHIA Is Valued By Stakeholders As a Neutral Convener That Helps Stakeholders Establish Shared Goals

The Michigan Health Improvement Alliance, Inc., or MiHIA (pronounced ma-high-ah), is a formal 501(c)3, multisector partnership working to achieve health excellence for the 14-county region it serves. This initiative is based on a core belief that solutions to health and health care problems can be found and designed at a regional level, accelerating regional competitive advantage and sustainability. MiHIA's work varies, but it all falls under what it calls the "Quadruple Aim," which targets health and systems broadly at the regional level. The Quadruple Aim focuses on four facets of health delivery—population health; patient experience; cost of care; and work-life balance for health care providers, clinicians, and staff. At the individual level, this translates to good or better health, high-quality care, and good value.

As the convener for multiple parties, MiHIA helps its stakeholders establish shared goals and objectives, set collective targets, and align business plans. Stakeholders value the opportunity to influence how the Quadruple Aim will be pursued in their community. If their own priorities are reflected in the decisions and outcomes, they often get more out of their own investment in health and health care. MiHIA's board of directors is comprised of representatives from every sector involved with MiHIA—including hospital systems, independent providers, universities, mental health organizations, consumers, health plans, economic development, nonprofits, and employers.

MiHIA Makes a Value Case to Each Stakeholder Organization to Secure Their Investment

MiHIA demonstrates to each stakeholder organization how it has helped that organization be more successful in achieving the organization's own mission and leveraging funding (for help making a case for your own work, see [Module 5](#)). Most importantly, each case presented by MiHIA details specific benefits that merit the stakeholder's ongoing participation and investment. The level of detail needed in the case depends on the stakeholder. Some examples:

A hospital's value case described how MiHIA supported a community organization in obtaining a grant that established county community health workers as part of a sustainable health system. As part of that grant, the hospital system got to utilize those workers, who already had full salary funding. MiHIA showed the hospital that it had access to \$3 million worth of value, thanks to this one grant alone.

MiHIA also built the capacity for a multi-county Diabetes Prevention Program, including bringing three master lifestyle coach trainers to the region, which enabled self-insured employers to offer the program as a covered benefit. This essentially secured hospitals a new, revenue-producing line of service. In addition, MiHIA maintains a database that holds information that helps hospitals complete their community health needs assessments.

A university's value case is different. MiHIA shows how its work supports the institutions in building the health professional pipeline as well as in securing research grants. The grants support work at the medical school and help attract faculty and students.

⁸ Beth Roszatycki and Catherine Baase, interview by Stacy Becker, October 4, 2016.



Stakeholders from various sectors are willing and able to pay MiHIA in the following two ways:

1. **Corporate contributions** (total dues of \$225,000–\$300,000 annually to fund operations for integrative activities). MiHIA approaches each stakeholder represented on the board of directors with its specific value case and asks for a multi-year payment commitment. Typically, MiHIA proposes an amount the stakeholder should pay. Upon agreement, MiHIA asks the stakeholder to sign a commitment letter and sends invoices annually.

There are two formats in which corporate contributions are requested by MiHIA. One format is a contribution based on the number of covered lives in their benefit plan per year. Employers spend \$7,000–\$8,000 a year per covered life already, so MiHIA requests a contribution of \$3 per covered life (a small amount, mainly for the employers to show commitment to the community's goals). MiHIA also makes the case that this would improve the value of every dollar the employers spends on benefits.

The second format is a flat contribution request to each organization, asking each to pay a predetermined amount depending on its size (for example \$10,000 if you have x number of employees, \$5,000 if y number, and so on).

2. **Via an affiliate organization, which was established by MiHIA** (currently earns \$20,000 annually; goal is to work to \$25,000 to fund operations for integrative activities). Some of MiHIA's largest stakeholders (e.g., pharmaceutical companies, pharmacies, insurers) have money designated for increasing their corporate presence in the community but are unable to make direct contributions. Some of those stakeholders suggested that they could contribute funds for MiHIA to use for general operations if it were a membership organization. However, becoming a membership organization would have potentially disrupted its corporate contributions, so MiHIA looked for alternatives. Catherine Baase, chairperson of the MiHIA board of directors and former chief health officer at The Dow Chemical Company (a major anchor organization and employer in the region), had observed that other professional organizations have affiliates with the sole mission of accepting funds to support the mission and functioning of the professional organization. In 2016, MiHIA decided to establish such an affiliate organization, which would allow these contributors to be publicly named affiliates (listed on the website) who are recognized as highly committed participants, which gives the added benefit of name recognition.

What Are the Challenges?

- *There is only so much capacity and making individualized value cases for each stakeholder takes work.* MiHIA is grappling with the question of how much time it should put toward soliciting funding (managing communications, preparing customized value cases for each stakeholder, etc.) as compared to doing the work that is actually of value to the organizations and convinces them to contribute. “We are always examining the best use of our time and resources,” said Baase.
- *MiHIA staff and members could get too insulated in their own community.* They strive to consistently look across the nation at other multisector partnerships, organizations, and industries to learn new and different ways of going about their financing work.

Trenton Health Team (THT)⁹

WEBSITE: TrentonHealthTeam.org

Integrative Activities THT Gets Paid For:

- **Monitoring, measuring, and evaluating region-wide efforts.** THT works with its partner-members to design and monitor regional health care performance, using a regional health information exchange (HIE).
- **Implementing strategy and managing performance of region-wide efforts.** THT consistently works to ensure that HIE data can be used to help partner-members design initiatives that focus on areas of highest need and evaluate progress. The HIE also uses data on high utilizers of services to support THT's Care Management Team, which helps patients manage chronic conditions and access services in an effort to decrease emergency room visits.

DEFINITION

A Health Information Exchange (HIE) system allows health care providers and patients to securely share a patient's medical information electronically—standardizing data and improving the speed, quality, safety, and cost of patient care.

Trenton Health Team Creates Value for Its Partner-members Through Five Initiatives That Address Lack of Collaboration Among Care Providers

Trenton Health Team (THT) first came together in 2006 as the [result](#)¹⁰ of a report commissioned by Mayor Douglas Palmer to assess the impact of the proposed closure of Mercer Hospital. In February 2006, the Mayor of Trenton commissioned a study to research and develop a plan for improving the health status of Trenton's residents and increasing access to health care services. The study found that residents of Trenton, New Jersey did not have consistent access to primary care; accessed numerous, disconnected providers; and utilized emergency departments to meet their health needs—despite being served by three hospitals, a federally qualified health center, and a city health clinic.

As a result, the health status of Trenton residents was lower than their Mercer County neighbors and the rest of New Jersey. The study also recognized that the utilization of hospital emergency rooms by city residents was 54 percent higher than the national norm, leading to costly, inefficient, duplicative, episodic, and unsatisfactory health care. The study's final report recommended that the city's care providers collaborate to solve these health care problems.

As described on THT's website, "fierce competitors" came together to respond to this call for action. As those providers began to find common ground, a partnership grew. THT was formally constituted as a 501(c)(3) in February of 2010 to conduct a number of integrative activities for the partners. The partnership included more than 60 different community organizations, representing a variety of municipal, county, and state agencies; social service groups; the faith community; and higher education. Together these community organizations serve as members of THT's board of directors, its subcommittees, or community advisory board. THT's mission is two-fold: to make Trenton the healthiest city in the state, and to transform and reform the health care system. Today, THT is working to make this vision a reality by conducting integrative activities for five strategic initiatives:

- Expansion of access to primary care
- Community-wide clinical care coordination
- Engagement of residents
- Operation of the Trenton health information exchange (HIE)
- Serving as a Medicaid Accountable Care Organization (ACO)

⁹ Greg Paulson, interview by Kim Farris-Berg and Lindsey Alexander, April 7, 2017. Follow-up interview by Katherine Wright, March 29, 2018.

¹⁰ <https://trentonhealthteam.org/wp-content/uploads/Making-Trentons-Healthcare-Plans-A-Reality-August-7-2006.pdf>



In Addition to Grants, THT and Its Five Initiatives Generate Two Revenue Streams: Annual HIE Membership Fees and Service Contracts

THT receives grants, which reimburse some of the indirect costs of conducting integrative activities for its initiatives (including salaries). General operation costs are covered using unrestricted funds from two additional revenue sources:

- 1. Annual HIE membership fees from health practitioners who pay to access integrated and holistic patient records in real-time to support treatment decisions and strategies.** Since Trenton is a relatively small community with safety-net providers and hospitals, and since THT partner-members want to limit financial barriers to using the HIE, the annual HIE membership fee pricing model is more appropriate for the community than the more expensive traditional usage-based pricing model. Membership fees are set by the HIE Steering Committee, which is comprised of representatives of each member institution. The fees are based on institution type, ranging from approximately \$15k for smaller clinics to more than \$100k for hospitals. The HIE launched in January of 2014 using a health-based information technology vendor, CareEvolution, and quickly grew as providers learned the value of the HIE's data. Now more than 600 clinical users have access to millions of clinical and Medicaid claims records for more than 250,000 patients. The data partners include fourteen participating institutions that contribute to the HIE by sending or receiving data.
- 2. Member organizations and other organizational partners contract THT for services.** For example, partners (both health plans and hospitals) contract with THT for the services of its Care Management Team, a highly effective and scalable service, which helps patients access a range of services. The Care Management Team provides basic health education, connects patients to social services, takes them to the pharmacy, and/or accompanies them to appointments. Health practitioners also contract with THT to access more complex, specific HIE services that do not come with the basic package as part of the annual membership fee. The Care Management Team currently creates just enough revenue to cover its costs, which are relatively high, due to the intensity of the work.

Overall, the Care Management Team service contracts and the HIE membership fees generate revenue which THT uses to cover Care Management Team costs, general infrastructure costs, and the rare initiative costs that happen to exceed their allotted budget, which are essential to the mission.

Data Generated By THT's HIE Is a Revenue Source That Also Helps Ensure Better Patient Treatment Across the Region

In Trenton, the HIE plays a vital role in advancing efforts to improve population health, allowing THT to generate integrated reports designed to identify issues and trends around particular health needs or disease conditions. THT's HIE does this for clinical organizations, public health agencies, and more. THT regularly solicits feedback from users to ensure that the HIE is serving their needs and remains an effective tool for regional health improvement. THT's goal is not only to provide the right data to organizations but also expertise to help partners interpret the data correctly (for instance, a partner might know what they want to learn, but not know how to use the data to find the answer).

Currently, THT is partnering with a small payer (covering about 3,000 lives) that is using the HIE data. Greg Paulson, executive director of THT, reports, "The payer cannot believe everything they can now see because they're used to only seeing claims data. They previously did not know about an ER visit for 90 days, but now they can see who of their members were in the ER yesterday. This is revolutionary to them." Without such information in the past, this payer was unable to track their member population and their health in real time. Now, with one system of aggregated data, THT and others can "watch" how patients move through the community in a way that is timelier and more cost-efficient than ever before.

As Paulson says, "Partners get both a data source and something of a consulting piece" when using the HIE, and partners are looking for answers to difficult, pressing questions so "they can reflect the technology back to their day jobs."

THT's Care Management Team would also be less efficient and effective without this information. When relying on the ER for care, patients receive treatment from different clinicians, which can result in fragmented and



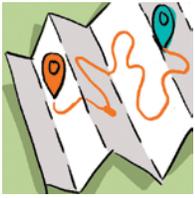
sometimes repetitive or contradictory treatment. The Care Management Team, on the other hand, offers complete care, known as wrap-around services, which include help accessing social and psychological services as well as primary health care. They need to access new and different data in new and different ways.

THT is at the forefront of using cross-institutional and combined claims and clinical data to direct and monitor population level health improvement activities. “Using the capabilities of the HIE to pinpoint community needs,” Paulson says, “users are able to move beyond just getting records on one patient.” While the Care Management Team doesn’t generate a revenue margin, it is a critical part of meeting the individual need in the community. As Paulson says, “Creating data systems is great, but if you don’t get out to the people and help them get their needs met...it is all for naught. The Care Management Team functions as an important part of our intervention to connect individuals in the community and provide the services they need.” Their work is made all the more effective because it is built around the HIE’s ability to report on the needs in the community.

What Are the Challenges?

- *Promotion of the HIE and Care Management Team’s ongoing value is necessary—and expensive.* Most of the revenue generated from the HIE goes into ongoing efforts to recruit new users and remind current users of its value. This promotional work has a cost that must be factored in when considering how much funding the HIE might generate.
- *Infrastructure costs, and associated staff costs, are expensive given the cost of health IT systems in general.* THT, and other organizations running HIEs in New Jersey, are wrestling with how to design their ongoing business models to cover high infrastructure and staffing costs. Federal and state grants paid for the early work, but aggregating and effectively analyzing disparate data sources in order to improve health outcomes is expensive.

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Some Final Thoughts—and Many Thanks!

CONCLUSION AND ACKNOWLEDGEMENTS



Let's wrap things up and take a moment to thank those who made this workbook possible.

“ A financing practice requires practice. Keep at it!

Conclusion

If you worked through any of the material in this workbook, you've taken your first steps *beyond the grant!*

Maybe you haven't seen new money come in the door just yet, but you are—at a minimum—beyond the grant in how you think about the work of financing. Maybe you've identified or brought a critical perspective or partner to the table. Perhaps you've pinpointed a source of funding that matches up well with your multisector partnership's or organization's skills and abilities (or even just discovered some opportunities to build needed skills). Or maybe you have a deeper appreciation for the ways in which you create value—even if you haven't completely captured it just yet.

A Few Final Points

First off, remember from the Introduction: a financing practice requires practice. Keep at it! Bring new voices and perspectives to the table and see if and how your results evolve. Revisit and update your financial plans often. Expand your depth of knowledge about the health ecosystem around you. Keep honing your financing practice and you'll increase your opportunities to make your work more sustainable.

Secondly, [ReThink Health asserts](#)¹ there are three key practice areas for multisector partnerships and organizations working to transform health and well-being in their regions. Sustainable financing is one of them, but there are two more: active stewardship and comprehensive strategy. Developing your stewardship and strategy practices will no doubt help your financing practice. You might consider exploring [The ReThinkers' Blog](#)², [Stewardship Guide](#)³, [Dynamics Model](#)⁴, or any of the tools we provide on [our website \(www.rethinkhealth.org\)](#).

Lastly, please share your stories and progress with us. We're always interested in hearing from you, and we're hoping you'll follow up around four areas in particular:

1. New financing structures you implement or discover (we'd love to continually update [A Typology of Potential Financing Structures for Population Health](#) from [Module 3](#) with additional examples or new takes on existing structures)
2. Stories or updates on any other insights or progress this workbook enabled
3. Thoughts on where you'd like to see additional supplemental materials offered in this workbook so you can further explore the concepts
4. Your take on improvements or refinements we could make to the material. We've tested this workbook material out in a number of ways, and we believe the content is ready for you to gain the information you need to start your sustainable financing practice. That said, we consider this version of the workbook a work in progress; we're still open to improvements based on your experiences with it.

So please connect with us—via email at ThinkWithUs@ReThinkHealth.org, on [Twitter \(@ReThinkHealth\)](#), or on [Facebook \(@ReThinkHealthInsights\)](#)—and let us know about your financing work!

We believe in the important work you are doing to help make your region a healthier place to live and work. We hope this workbook helps you take your financing to a new level. We look forward to hearing about your current endeavors and future progress!

¹ <https://www.rethinkhealth.org/about-us/our-approach/>

² <https://www.rethinkhealth.org/resources-list/the-rethinkers-blog/>

³ <https://www.rethinkhealth.org/tools/stewardship-guide/>

⁴ <https://www.rethinkhealth.org/resources-list/dynamic-modeling-strategy/>



Acknowledgements

The Rippel Foundation is profoundly grateful for all of those who contributed to *Beyond the Grant: A Sustainable Financing Workbook*, a product of our ReThink Health initiative. This workbook is the result of a few years of work, which started with a lot of learning about the state of multisector partnerships' financing to ensure this resource would provide the right exercises to get them over their hurdles. We drew information from extensive phone interviews with a variety of participants from our annual Pulse Check Survey; most of the examples shared throughout the workbook came from those calls.

Once the first draft of the content was complete, we engaged in a series of tests to learn whether:

1. the materials were clear and understandable
2. the materials helped multisector partnerships and organizations aligning with them
3. the workbook would add to the field of health system transformation in general

The answers were usually, “yes, but with some refinements.” Many researchers, thought leaders, and practitioners helped us make those refinements, which dramatically improved how we presented the material. We are indebted to them for their honest and clear feedback, and especially for the time they gave to making this workbook better.

Scores of individuals who contributed to this workbook in meaningful ways, including the following:

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2015 Pulse Check survey respondents

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- Wellness Now Coalition:** Carrie Blumert
- Alliance for a Healthier South Carolina:** Rick Foster and Lindsey Perret

We would also like to thank all of the professionals out in the field—leaders and members of multisector partnerships and organizations—who are hustling day in and day out to improve the health of their communities. Keep it up! With your tireless commitment, we have every confidence you will move beyond the grant.

Many thanks to our illustrator, Craig Nordeen, for applying his creative magic (and patience) to a financing workbook and generating the compelling and original illustrations you see throughout the workbook and its website. Craig brought this material to life in a way that words alone could never do.

Special thanks to Robin Hacke, executive director of the Center for Community Investment, for her generous feedback on *A Typology of Potential Financing Structures for Population Health*. Thanks to Ruth Wageman and Sherry Immediato, two of our colleagues at The Rippel Foundation, for sharing their insights into integrative functions, which enriched the material in Module 7.

Lastly, we would like to thank all our colleagues at The Rippel Foundation who reviewed and revised this material, improving it in important ways, in both content and style. Thank you for helping to shape and define our ideas and ensure that our final product is clear, compelling, and relevant. It's an honor to be on your team.

- *Lindsey Alexander, Stacy Becker, Kim Farris-Berg, and Katherine Wright*

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Let's Get on the Same Page about Terminology.

Cracking open the workbook and seeing some terms you don't recognize? You're not alone, so we've put together this glossary. Refer to it as needed while you explore the workbook!

GLOSSARY





Glossary

Anchor organization: A large institution that has a vested interest in a region's prosperity and is unlikely to leave the region; common examples include hospital systems, universities, and major regional employers.

Avoided cost: A cost that would have been incurred if action had not been taken to prevent it. In population health, this may occur when an intervention saves money downstream. When this happens, the intervention doesn't produce actual revenue, but will result in an organization avoiding future health care costs.

Comparables (comps): Things with known values that share similar characteristics to something with an unknown value that you are trying to determine, giving you a basis for comparison.

Financial flows: The path money takes from its source through financing mechanisms on its route to a specific destination. One simplified example: if you buy a soda for one dollar, that dollar's financial flow starts with you, flows through the shopkeeper, then out to the soda distributor and manufacturer.

Financial plan: A schedule of current and future intended uses of money and—ideally—predicted sources of that money (i.e., *what do we need money for, how much, where from, and over what period of time?*).

Financing: The process of developing and balancing your financial sources (where money comes from) with uses (what money is spent on).

Financing mechanisms: Techniques or instruments used to pool, distribute, and/or transfer funds (which come from a source).

Financing structure: A system of decisions, protocols, procedures, and authorities that govern how money from a source gets distributed.

Funding: Money provided for a particular purpose, which may or may not have to be repaid.

Health ecosystem: A system composed of an extensive collection of distinct variables and organizations that depend on and interact with one another to produce health and well-being in a region.

Integrative activity: Roles and leadership functions for governing and managing the work happening within and across multisector partnerships in a region, to achieve a common purpose. See Appendix 1 for a list of examples.

Intervention: A policy, program, or practice that regional leaders design to help produce health and well-being in the region.

Multisector partnership: A group of regional leaders who have working relationships with one another, across organizations and sectors, to achieve a common purpose related to health and well-being.

Neutral convener: A person or organization that brings others together to collaborate on an issue but does not take a side, engage in negotiations, or have a direct interest in the outcome. Often, a convener takes responsibility for the management and administrative tasks needed to provide a platform for negotiation and collaboration.

Portfolio of interventions: A balanced and impactful set of policies, programs, and practices that regional leaders select as the "right mix" to produce health and well-being in the region.

Population health and well-being: Often shortened to "population health," "health and well-being," or simply "health" in this workbook, this denotes the overall level and distribution of healthiness and quality of life for all people within a given region. It is not limited to the healing or strengthening of the body against injury and disease, but instead includes all aspects of well-being, including physical and psychological health, security, economic prosperity, connectedness, and more.

Return on investment (ROI): A statement of the amount of value resulting from a given investment.

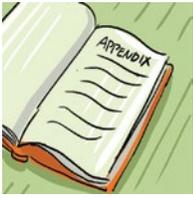
Stewardship: The act of regional leaders working together across boundaries to create the conditions for equitable health and well-being. This involves perpetual efforts to negotiate shared values, establish and enforce norms, resolve conflict, and adapt to changing circumstances in a common world.

Strategy: High-level planning about what you want to do and why it will be impactful. In population health, strategy equips leaders with data and dynamic models to help them individually and collectively understand the complexity and interactions of their health system, play out plausible scenarios, identify opportunities, set priorities for action, and measure progress over time.

System: A set of interacting or interrelated parts with a specific purpose. In this workbook, system is often used as shorthand for health ecosystem.



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The Nitty-Gritty of Integrative Activities and Financing Structures.

Want a reference for what integrative activities are and how to demonstrate their value? How about more details on financing structures? We've got you covered!

APPENDICES





APPENDIX 1 | Integrative Activities

More information about integrative activities is available on page 9 of the Workbook's Introduction, "What Is This Thing? Will It Really Help You Finance Your Work?"

Integrative Activities		Specific Roles and Leadership Functions
1	Convening Stakeholders for Cross-sector Collaboration and Information Sharing	<ol style="list-style-type: none"> 1. Engage stakeholders or multisector partnerships 2. Build public will 3. Enroll others in advocacy via convening/organizing 4. Determine agenda 5. Facilitate networking among key leaders 6. Provide communications support, including partnering with conveners to build public will (e.g., website, newsletters, outreach) 7. Manage meeting logistics 8. Create detailed meeting design, including preparation and follow-up
2	Analyzing and Planning for Regional Health Improvement	<ol style="list-style-type: none"> 1. Lead the setting of collective vision and goals; ensure resident involvement in the process 2. Devise shared strategy among stakeholders 3. Identify critical strategic questions, including differences in interests of stakeholders 4. Secure commitments to implement strategy 5. Advocate daily for goals and strategy (internal and external) 6. Facilitate strategy development process, including conducting of needs assessment 7. Serve as a neutral data synthesizer
3	Designing Ongoing Infrastructure and Governance	<ol style="list-style-type: none"> 1. Design and ratify shared governance structure as well as composition and decision-making rules 2. Provide strategic oversight of infrastructure and governance 3. Build relationships with other oversight groups 4. Provide facilitation for interim governance bodies to design governance changes over time 5. Manage recruitment, elections, and transitions in membership of governance bodies 6. Facilitate communications among oversight groups
4	Implementing Strategy; Managing Performance of Region-wide Efforts	<ol style="list-style-type: none"> 1. Strategic oversight of actual implementation; ensure accountability and effectiveness 2. Celebrate successes; share learnings 3. Direct and/or manage projects, which might be about supporting work groups or alignment of activities 4. Support stakeholders' abilities to work within the partnership (e.g., use the partnerships' systems for sharing data)
5	Catalyzing Innovation and Redesign	<ol style="list-style-type: none"> 1. Set audacious goals 2. Lead learning activities 3. Create conditions for innovation 4. Provide seed capital 5. Build human capacity to generate and test innovations 6. Conduct and synthesize research 7. Facilitate networking 8. Manage process of identifying innovations to pursue
6	Designing Financing Structure and Strategy	<ol style="list-style-type: none"> 1. Determine financing vision and strategic priorities 2. Create governance structure for funding decisions and accountability management 3. Determine financing structure for integrative activities 4. Mobilize funding to implement priorities and initiatives 5. Research possible financing structures and provide design support <ol style="list-style-type: none"> a. Develop charitable giving strategy b. Write grants 6. Administer grants, which might include acting as fiscal agent 7. Host innovation fund <ol style="list-style-type: none"> a. Receive and review applications b. Provide recommendations to governance body c. Act as fiscal agent for funds to be redistributed 8. Provide staff support for governance of financing
7	Advocating for Public Policy	<ol style="list-style-type: none"> 1. Set policy priorities 2. Build relationships with thought leaders and policymakers 3. Communicate impact of policies 4. Implement through influence campaigns and more
8	Monitoring, Measuring, and Evaluating Region-wide Efforts	<ol style="list-style-type: none"> 1. Provide strategic guidance and oversight of overall information system 2. Review results and modify action plans 3. Envision and develop process for sharing results with residents 4. Design and facilitate learning and improvement process 5. Monitor progress toward shared goals 6. Design and facilitate forums for accountability to residents

ReThink Health is maintaining a comprehensive list of integrative activities and how multisector partnerships and other organizations are getting paid for conducting them. Please email ThinkWithUs@rethinkhealth.org with any suggested additions.



APPENDIX 2 | Integrative Activities Evidence

As described in [Module 5](#), the evidence base for the value integrative activities create is not large, but we believe such activities are essential components for health system transformation. Below are examples of the type of evidence—in the form of journal articles, news stories, or white papers—that could be used as a starting point when building a value case for integrative activities.

We present each item starting with the **article's title**, then we highlight a few key quotes and provide the full citation so you can learn more. The quotes are meant to give you a sense of what evidence the article or research presents and are taken out of context. If you read them and find your interest piqued or wonder about definitions or more detail, you can follow the link to read the full article.

We split the evidence into three **categories**: one that demonstrates the value of people and organizations that perform integrative activities, another that displays the value of the integrative activities themselves, and a third for other resources.

Value of People and Organizations That Perform Integrative Activities

Integrative Public Leadership: Catalyzing Collaboration to Create Public Value

QUOTES

“Integrative public leadership is a process of developing partnerships across organizational, sectoral, and/or jurisdictional boundaries that create public value.”

“Boundary organizations provide a structural context for partnership development; boundary experiences and boundary objects serve to bridge differences and create a common purpose; and boundary spanners exhibit entrepreneurial qualities and leverage relationship capital in order to facilitate integration.”

Morse, Ricardo S. “Integrative Public Leadership: Catalyzing Collaboration to Create Public Value.” *The Leadership Quarterly*, Public Integrative Leadership, 21(2) (2010): 231–45. <https://doi.org/10.1016/j.leaqua.2010.01.004>.

The Leadership Premium: How Companies Win the Confidence of Investors

QUOTES

“On average, we discovered a premium of 15.7 percent for particularly effective leadership—and a discount of 19.8 percent for its opposite.”

“Furthermore, leaders in small companies tend to be less constrained in their actions by long-established processes and protocols, giving them more freedom to alter the direction of the company.”

Deloitte. “The Leadership Premium: How Companies Win the Confidence of Investors.” 2012. <https://www2.deloitte.com/content/dam/Deloitte/global/Documents/HumanCapital/dttl-hc-leadershippremium-8092013.pdf>.



Calculating the Market Value of Leadership

QUOTE

“Wise, long-term investors recognize that leadership affects firm performance. But too often, assessments of leadership are haphazard and narrow. For instance, in our research, we found that investors allocate about 30% of their decision making based on quality of leadership, and they have much less confidence in their ability to assess leadership than in their assessments of financial or intangible performance.”

Freed, Allan, and Dave Ulrich. “Calculating the Market Value of Leadership.” *Harvard Business Review*, April 2015. <https://hbr.org/2015/04/calculating-the-market-value-of-leadership>.

Great Leaders Can Double Profits, Research Shows

QUOTE

“In summary, poor leaders lost money; good leaders made profit; and extraordinary leaders more than doubled the company’s profits in comparison to the other 90%!”

Zenger, Jack. “Great Leaders Can Double Profits, Research Shows.” *Forbes*, January 15, 2015. <https://www.forbes.com/sites/jackzenger/2015/01/15/great-leaders-can-double-profits-research-shows/>.

Case Study: The Power of Convening for Social Impact

QUOTE

“Bringing people together in an environment that encourages and facilitates idea exchange is one of the most powerful communications strategies for driving change.”

Borgman, Sarah Zak. “The Power of Convening for Social Impact (SSIR).” *Stanford Social Innovation Review*, March 2016. https://ssir.org/articles/entry/the_power_of_convening_for_social_impact.

Ten Ways Data Integration Provides Business Value

QUOTES

“Many valuable data-driven business practices depend on one or more forms of data integration.”

“Data integration and related practices (such as data quality and master data management) add value to data, which in turn increases the value of business processes that use the data.”

Russom, Philip. “Ten Ways Data Integration Provides Business Value.” *Transforming Data with Intelligence*. May 18, 2011. <https://tdwi.org/articles/2011/05/18/ten-ways-data-integration-provides-business-value.aspx>.

Five Ways Innovation Can Boost Company Values

QUOTE

“Innovative companies are almost always more valuable. They offer more potential and investors are especially interested in companies who own patents or use innovative methods or technology to boost efficiency, save time, improve customer service, and drive profits. In short—innovation pays off over and over.”

Condit, Bruce. “Five Ways Innovation Can Boost Company Values.” *Inc.com*. April 8, 2015. <https://www.inc.com/bruce-condit/five-ways-innovation-can-boost-company-values.html>.



Creativity's Bottom Line: How Winning Companies Turn Creativity into Business Value and Growth

QUOTE

“But when we dug more deeply, we found that the most creative companies did certain things differently. Specifically, they exhibited a set of four business practices that we believe drive their marketing creativity, their ability to innovate, and their capacity to translate those virtues into business value.”

Brodherson, Marc, Jason Heller, Jesko Perrey, and David Remley. “Creativity's Bottom Line: How Winning Companies Turn Creativity into Business Value and Growth.” McKinsey & Company. June 2017. <https://www.mckinsey.com/business-functions/digital-mckinsey/our-insights/creativitys-bottom-line-how-winning-companies-turn-creativity-into-business-value-and-growth>.

Strategic Product Value Management: How Companies Can Improve Innovation, Reduce Costs, and Mitigate Risk

QUOTES

“In our 10-year analysis, need seekers* are more likely to show stronger financial performance than their competitors, and they are more likely to align their innovation strategy with their overall business strategy.”

“The ability to effectively manage risks has a direct correlation with a company's innovation success. It keeps the innovators focused on aligning their product or service with the customer's true needs, rather than just innovation for its own sake. In this way, risk management is akin to guardrails that establish the true boundaries for innovation and ensure that the resulting products or services link to the organization's overall strategy and fulfill their mandate of creating value for customers.”

** The article defines a “need seeker” as companies “such as Apple, Procter & Gamble, and Tesla, [that] use superior insights about their customers to generate new product ideas.”*

Moebius, Reinhard, and Volker Staack. “Strategic Product Value Management: How Companies Can Improve Innovation, Reduce Costs, and Mitigate Risk.” Strategy&. July 29, 2015. <https://www.strategyand.pwc.com/reports/strategic-product-value-management>.

Stories about Value of Integrative Activities

Lessons Learned from Our Conversations with Experienced Backbone Leaders

QUOTES

“Good backbone leaders build the capacity of others to continue the work in light of uncertainties such as elected officials' coming and going, funding fluctuations, and personnel turnover in partner organizations. According to Kat Allen at Communities that Care Coalition, “the reality is that funding can go away at any time and we have to be prepared to leave a legacy of effective strategies and population-level change. When we set up a new strategy, we are thinking about long-term sustainability from the get-go . . . we have built buy-in and capacity so that our stakeholders are doing the work themselves.” Chekemma Fulmore-Townsend at Project U-Turn concurs, noting, “To sustain the initiative, it can't be just my job. In Philadelphia, there is a real sense of communal ownership around moving the needle.”

“Experienced backbone leaders have an exceptional instinct for managing interpersonal dynamics. For example, Chekemma Fulmore-Townsend makes sure to include key stakeholders before reports are released: “We vet the data with leaders in the system [before releasing important reports]. Of all the things we do to advance partnerships and align to the common goal, vetting reports with system leaders prior to publication is the most powerful approach we have.”

Phillips, David. “Lessons Learned from Our Conversations with Experienced Backbone Leaders.” *Collective Impact Forum*. August 1, 2016. <http://collectiveimpactforum.org/blogs/1021/lessons-learned-our-conversations-experienced-backbone-leaders>.



Measuring Backbone Contributions to Collective Impact

QUOTES

This article highlighted four measures of influence that can help to demonstrate the backbone's contributions:

Leveraged funding

"Certain stakeholders seek a single quantitative measure of a backbone's contributions. For such individuals or groups, it can be useful to provide an estimate of the amount of funding that the backbone organization has helped to catalyze, pool, or redirect in support of the initiative's common agenda."

"Measuring leverage is one of the most powerful ways to demonstrate the strategic nature and fundamental difference of investing in a backbone organization, as opposed to more traditional program investments."

Indicators of initiative progress

"Backbones can also share initial project outcomes—related to either process or initiative-level impacts—as a measure of their influence. Initiative-level indicators, such as legislation passed in support of common goals, can demonstrate how a backbone is critical to moving the needle on social problems."

Evidence of systems change

"During interviews with stakeholders in the Greater Cincinnati region, we found that one of the best ways to gauge a backbone's influence was to listen to the stories that participants shared about systems changes in their communities. These stories describe the shifts taking place in the way that the community makes decisions about policies, programs, and/or the allocation of its resources, and in the way the community delivers services and supports its citizens."

Stakeholder perceptions of backbone value

"Observations from community members about the importance of the backbone organization can further help to define its influence."

Turner, Shiloh, Katherine Errecart, and Anjali Bhatt. "Measuring Backbone Contributions to Collective Impact." *Stanford Social Innovation Review*. 2016. https://ssir.org/articles/entry/measuring_backbone_contributions_to_collective_impact.

The Ecosystem of Shared Value

QUOTE

"The backbone function ensures that all the working groups remain aligned and informed. Companies cannot be the backbone—they are not neutral players. They can, however, provide funding to launch it, technology support for online communication, and mentoring or coaching...."

Kramer, Mark R., and Marc W. Pfitzer. "The Ecosystem of Shared Value." *Harvard Business Review*. October 2016. <https://hbr.org/2016/10/the-ecosystem-of-shared-value>.

Other Resources

(Mis)Understanding Overhead

QUOTE

"Indeed, more people are realizing that costs may have nothing to do with how effective a nonprofit is. In fact, overhead that is too low is more concerning as it relates to effectiveness. Instead the focus is shifting toward a nonprofit's *impact and effectiveness*. It is our hope that everyone who invests in a charitable nonprofit's mission—the staff and board of a nonprofit, as well as individual donors, businesses, private foundations, and government—become aware that operating a charity is not free (gasp!). *It costs something to deliver a nonprofit's mission.*"

"(Mis)Understanding Overhead." National Council of Nonprofits. January 14, 2015. <https://www.councilofnonprofits.org/tools-resources/misunderstanding-overhead>.



The Overhead Myth: Moving Toward an Overhead Solution

QUOTE

“We write to ask for your help to end the Overhead Myth—the false conception that financial ratios are a proxy for overall nonprofit performance. Last year we wrote a letter to the donors of America asking them to consider the results (especially outcomes and impact) created by nonprofits, and to not judge you solely on percent of charity expenses that go to administrative and fundraising costs. While overhead can help us identify cases of fraud or gross mismanagement and serve as a part of an organization’s dashboard of financial management metrics, it tells us nothing about the results of your work (i.e., how you meet your mission).”

Taylor, Art, Jacob Harold, and Ken Berger. “The Overhead Myth: Moving Toward an Overhead Solution,” October 2014. http://overheadmyth.com/wp-content/uploads/2014/10/Overhead-Myth_Letter-to-the-Nonprofits-of-America.pdf.

Unrestricted Core Support: Strengthening the Capacity of our Nonprofit Sector

QUOTES:

“Core support is the ‘working capital’ nonprofits need to sustain and strengthen their infrastructure in order to achieve organizational effectiveness.”

“In just three years, our core support funding has allowed our grantees to maintain and strengthen their capacity by: 1) continuing to support their core programs and services; 2) strengthening their organizational infrastructure; 3) providing the flexibility in funding to adapt, innovate, and take advantage of opportunities; 4) creating a more open and honest relationship with us; and 5) working together to establish clear outcomes and objectives.”

Weingart Foundation. “Unrestricted Core Support: Strengthening the Capacity of Our Nonprofit Sector.” April 2012. <http://www.weingartfnd.org/files/core-support-report.pdf>.

Why Funding Overhead Is Not the Real Issue: The Case to Cover Full Costs

QUOTE:

“Paying nonprofits their full costs is how we prevent crises and interrupted services for communities and allow leadership to stay focused on mission and outcomes. Anyone who has worked in a cash-constrained nonprofit knows that when a cash-flow crisis hits, mission stops, strategy stops, and all the energies of management and board are diverted to moving up receivables, delaying payables, and securing cash however they can. Appropriate working capital prevents program disruption due to cash flow shortfalls.”

Knowlton, Claire. “Why funding Overhead is Not the Real Issue: The Case to Cover Full Costs.” September 12, 2018. <https://nonprofitquarterly.org/2018/09/12/why-funding-overhead-is-not-the-real-issue-the-case-to-cover-full-costs/>.



APPENDIX 3 | Financing Structures for Population Health

In [Module 3](#), we briefly explain different types of financing structures, and provide details in [A Typology of Potential Financing Structures for Population Health](#). If you're still confused about something—or just want to learn more about financing structures—this appendix further explores some structures that often elicit more questions.

Financing structures that need to be repaid include Bonds, Loans, Pay-for-Success, and Equity Investments. When used for the purpose of population health, they can be categorized as “social impact investing.” You can learn more about them in a paper from the California Accountable Communities for Health Initiative (CACHI) and ReThink Health: [“The ABCs of Social Impact Investing.”](#)¹ The paper goes into more detail about those financing structures, along with possible options for social impact investing, such as Program-Related and Mission-Related Investments, Community Development Loans, Mini-Bonds, and Opportunity Zones.

Dedicated public revenues include dedicated taxes, tax expenditures (i.e., tax breaks), and fees. These revenue sources differ from general taxes, like property taxes and income taxes, which are collected and distributed through a public appropriation (or budgeting) process because they are levied for specific purposes. State and local governments with dedicated public revenues include:

- Bernalillo County in New Mexico has approved a behavioral health tax, yielding \$20 million annually.²
- When new medical facilities are built in Massachusetts, a fee equal to five percent of the development cost is levied, and distributed to local integrator organizations.³
- Massachusetts also provides homeowners with a lead paint abatement tax credit.⁴
- Voters in Philadelphia⁵ and Berkeley⁶ have approved sugary beverage taxes.
- Maryland offers tax credits for health care professionals who move to underserved areas.⁷
- In Oregon, King County's Best Starts for Kids intervention is funded by a \$65 million a year property tax levy.⁸

Earned income is money generated from paid work. A multisector partnership or organization may offer services or products that others want to purchase, such as serving as a fiscal agent, or preparing a community needs assessment. Trenton Health Team, a multisector partnership, receives membership fees from health practitioners for use of its Health Information Exchange. The Health Improvement Partnership of Santa Cruz County earns income from adhering to a set contract to provide services, such as continuing medical education programming for providers, in the community.

Health care payment models are payment schemes for health care services. Fee-for-service, bundled payment, and the structure for financing patient-centered medical homes are just a few examples. Increasingly the emphasis is shifting to “value-based payments”—that is, payments that in some way hold providers accountable for the quality and/or cost of the services they provide. In some cases, new payment models provide funding for non-clinical services, such as a diabetes prevention program or community health workers. A focus on value also opens the door to shared savings agreements, like those used by some accountable care organizations.⁹

Institutional purchasing and investing comprises the set of decisions made by institutions regarding their own business decisions that can help—or hurt—the social determinants of health. Do they buy local? Are they environmental stewards? Do they create healthy workplaces? While this applies to any institution in a community, “anchor institutions” are the most notable because of their large size, which shapes the local economy as well as social and environmental conditions. Examples include large corporations, universities, and hospitals. Not just any large institution is an anchor institution. Anchor institutions recognize the impact of their footprint; acknowledge that their decisions have consequences in the community; and, accordingly, make investment and spending decisions for the betterment of the community. For example, Kaiser Permanente has invested in a green energy program in California, confident that this investment will help reduce asthma, among other benefits. Kaiser Permanente's approach is to use its non-clinical assets to improve all aspects of the environment to create and influence health.¹⁰ [A Typology of Potential Financing Structures for Population Health](#) in [Module 3](#), page 7 contains links to several excellent resources on anchor institutions.



Mandates are government policies—federal, state, or local—requiring that specific purposes be funded. The notorious “unfunded mandate” provides no funding but nonetheless is quite powerful because it forces the provision of financial resources for a specific purpose. The Americans With Disabilities Act is a great example of just how powerful a mandate can be.

Public appropriations are spending by government agencies for services, goods, or grants. This category of funding sources is especially important for two reasons. First, the primary funding source for the social determinants of health—e.g., affordable housing, public safety, clean environment—has traditionally been the public sector. Second, the combined mix of that spending, a public jurisdiction’s “portfolio,” is of critical importance to population health outcomes, that is, the general well-being of the region. That portfolio might be heavy on emergency services, such as homeless shelters, jails, and child welfare services, or it could focus more heavily on preventive measures that keep those emergencies from occurring in the first place. (Try the [Negotiating a Well-Being Portfolio Exercise](#)¹¹ on the ReThink Health website to learn more about portfolio construction.).

Reinvestment, in the corporate world, is the practice of taking excess revenue, or revenue that exceeds expenses, and placing it back into service in the same enterprise. Amazon is regarded as the poster child for reinvestment, choosing to continuously invest excess revenues in the company to propel growth rather than distribute them as profit.

Within the confines of a single organization such as Amazon, the process by which reinvestment occurs is straightforward because the same decision makers control the spending, reinvestment, and profit-sharing decisions. In comparison, reinvestment can be quite challenging for population health efforts. Generally speaking, to make reinvestment work, there must be protocols for measuring and accounting for savings, means to turn avoided savings into spendable cash, and agreements that distribute the funds. Without standardized models for reinvestment, the political and technical lift to put an agreement in place can be quite heavy.

One reason reinvestment can be challenging for population health efforts is that reinvestment typically involves excess cash; that is, revenues exceed costs, so there is cash available to reinvest. Most health care savings fall into a category known as *avoided costs*—savings on expenses not yet incurred. In those cases, there is no cash to reinvest—just avoided health care costs, which are harder to measure and capture.



Here’s an example to illustrate avoided costs: imagine your landlord is thinking she’ll need to raise your rent \$50 a month. Before she does, she implements a program that reduces water usage in your building, her utility costs go down, and she only has to raise rent by \$20. You won’t have more money in your pocket (indeed you have \$20 less), you just avoided paying even more (by \$30).

Another reinvestment challenge is that, unlike Amazon, which can make its own decisions about how much cash to distribute to shareholders and how much to plow back in the company, in population health we often want to move money from health care toward someplace else, such as a public health or social service agency. That’s politically tough in fragmented, siloed environments.

We know from our own [ReThink Health Dynamics Model](#)¹² that reinvestment can turbo boost available funding. For example, savings from clinical interventions can be reinvested in additional interventions that save more money, and those secondary savings are reinvested again to save even more money. Unfortunately, reinvestment remains a financing structure of considerable potential and little practice. One example is found in Central Oregon, where PacificSource remits revenues that exceed a specified margin on its Medicaid contract to a community fund. To date the fund has accumulated \$8 million.¹³



- ¹ The Rippel Foundation and California Accountable Communities for Health Initiative, "The ABCs of Social Impact Investing," July 2018. <http://cachi.org/uploads/resources/CA-CHI-Social-Impact-Investing-Final.pdf>.
- ² Bernalillo County, "Commission Approves Mental Health Measure," February 26, 2015. <https://www.bernco.gov/uploads/files/BH%20news%20release%20PDF.pdf>.⁵ The Commonwealth of Massachusetts Executive Office of Health and Human Services Department of Public Health, "Determination of Need Factor 9 Community Health Initiatives Policies and Procedures," revised August 19, 2014. <http://www.mass.gov/eohhs/docs/dph/quality/don/don-community-health-initiatives.pdf>.
- ³ Massachusetts Kids Count, "Tax Break for Removal of Lead Paint," updated August 2016. <http://children.massbudget.org/tax-break-removal-lead-paint>.
- ⁴ Margot Sanger-Katz, "Soda Tax Passes in Philadelphia, Advocates Ask: Who's Next?" *The New York Times*, June 16, 2016. <https://www.nytimes.com/2016/06/17/upshot/soda-tax-passes-in-philadelphia-advocates-ask-whos-next.html>.
- ⁵ Healthy Berkeley, "Berkeley's Tax Ordinance," accessed December 22, 2017. <http://www.healthyberkeley.com/about-berkeleys-tax-ordinance/>.
- ⁶ Maryland Department of Health, "Health Enterprise Zones (HEZs)," accessed June 15, 2017. <https://health.maryland.gov/healthenterprisezones/Pages/HOME.aspx>.
- ⁷ King County, "Best Starts for Kids," updated August 30, 2018. <http://www.kingcounty.gov/depts/community-human-services/initiatives/best-starts-for-kids.aspx>.
- ⁸ <https://www.rethinkhealth.org/resources/negotiating-a-well-being-portfolio-exercise/>.
- ⁹ Centers for Medicare & Medicaid Services, "About the Program," accessed August 17, 2017. <https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payments/sharedsavings-program/about.html>.
- ¹⁰ Kaiser Permanente, "Kaiser Permanente's Commitment to Renewable Energy," accessed October 8, 2018. <https://share.kaiserpermanente.org/wp-content/uploads/2015/02/Kaiser-Permanente-Sustainable-Energy-Infographic-Feb-2015.pdf>.
- ¹¹ <https://www.rethinkhealth.org/resources/negotiating-a-well-being-portfolio-exercise/>
- ¹² <https://www.rethinkhealth.org/resources-list/dynamic-modeling-strategy/>
- ¹⁴ Matt Guy, email to author, October 4, 2018.

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LEARN more at ReThinkHealth.org

Transforming the system that produces health and well-being is no small task. To do it well, regional leaders need to work together to intentionally take responsibility for facilitating the cross-sector collaboration and alignment that creates the conditions for lasting change. ReThink Health, an initiative of The Rippel Foundation, helps leaders understand what can expect when they work together to practice and develop their stewardship as part of their quest to create fair and just opportunities for everyone to reach their potential.

Visit [ReThinkHealth.org](https://www.rethinkhealth.org) to learn more about these and other projects and resources:



A Pathway for Transforming Health and Well-Being Through Regional Stewardship

<https://www.rethinkhealth.org/resources-list/pathway/>



Pulse Check on Multisector Partnerships

<https://www.rethinkhealth.org/tools/pulse-check/>



ReThink Health Dynamics Model

<https://www.rethinkhealth.org/resources-list/dynamic-modeling-strategy/>



ReThink Health Ventures

<https://www.rethinkhealth.org/our-work/rethink-health-ventures/>



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Lindsey Alexander and **Stacy Becker** are seasoned financing and public policy professionals. With **The Rippel Foundation**, they've worked directly with multisector partnerships for health to learn the best and most practical ways to address common challenges with sustainable financing. If you're one of the 90% of partnerships relying on short-term grants to fund your population health efforts, mastering the concepts in *Beyond the Grant* will put you on the path toward sustainability.

“

At a meeting with representatives from communities across the country, I watched a room full of people come alive and frantically take notes when colleagues at ReThink Health showed them a draft of this workbook. They found it useful, were vocally appreciative, and wanted to be able to share it back home. I am a proponent of practical guidance that helps busy people know what to do when they are working through complicated challenges, and *Beyond the Grant* is that.

Hilary Heishman
Senior Program Officer
Robert Wood Johnson Foundation

ReThink Health gives us the financing gizmos we need to make our vision of equity and wellness for all communities a reality. Their step-by-step tools help us answer all of our questions about how we can move from a traditional financing mindset to a broad-based approach to sustainable funding.

Kitty Bailey
Executive Director
Be There San Diego

We often ask clients to take stock of their assets, and assess capacity to know and demonstrate the value they deliver to a range of audiences. The ReThink Health workbook supports this critical thinking and value mapping process, and provides exactly the right level of practical guidance for organizations to start this process on their own—providing useful direction and instructive prompts at multiple points along the way.

Alison Rein
Director, Health
Quantified Ventures

Local elected officials and city agency staff address social determinants of health every day in resource-constrained contexts. This financing workbook emphasizes partnerships and strategies that are pre-requisites to funding and helps city leaders think through a range of financing structures and their applicability in different contexts. Special thanks to ReThink Health for creating this practical, valuable resource for the wider community.

Kitty Hsu Dana
Senior Health Policy Advisor
National League of Cities

“

I'm much braver about standing up for the value of my work now, thanks to this financing workbook!

Donna Mills
Executive Director
Central Oregon Health Council



www.ReThinkHealth.org/financingworkbook/