Sustaining and Scaling Health Equity Impact
A Toolkit for Funders and Grantees

MAY 2020
This toolkit was developed by FSG in partnership with the Bristol-Myers Squibb Foundation based on experiences of the Foundation’s grantee partners in sustaining and scaling health equity initiatives.

The mission of the Bristol-Myers Squibb Foundation is to help reduce health disparities by strengthening community-based health care worker capacity, integrating medical care and community-based supportive services, and mobilizing communities in the fight against disease.

FSG is a mission-driven consulting firm supporting leaders in creating large-scale, lasting social change. Through strategy, evaluation, and research we help many types of actors—individually and collectively—make progress against the world’s toughest problems.
What is Sustainability?

“Sustainability is not just about funding. It’s about creating and building momentum to maintain community-wide change by organizing and maximizing community assets and resources. It means institutionalizing policies and practices within communities and organizations.”

— National Center for Chronic Disease Prevention and Health Promotion

Source: A Sustainability Planning Guide for Healthy Communities, Centers for Disease Control and Prevention
How Can This Toolkit Help You?

- The toolkit can help organizations take a **structured approach to developing and sustaining programs** by engaging new and untraditional partners as part of a sustainability plan.

- This toolkit is intended to support organizations in **building comprehensive programs** that promote **improved health outcomes and equity** by bridging medical care and community-based services.

- For **grant recipients early in their work**, this toolkit can support the **development of a strong plan for sustainability from the outset of the project** through strategic planning, early partnership development, and monitoring & evaluation design.

- For **grant recipients later in their work**, this toolkit can support **strategy adjustments and ongoing efforts to identify and engage partners** for sustaining work beyond a specific grant or pilot project.

- For **funders**, this toolkit is a **resource to share with grantees** to support them in reaching sustainability, scale, and replicability to achieve catalytic impact.
INTRODUCTION
Understand sustainability and how to approach sustainability planning

1. DEVELOP A SUSTAINABILITY VISION
Define a long-term vision for your work beyond an individual grant

2. ESTABLISH SUSTAINABILITY GOALS
Embed sustainability goals and activities in your project strategy

3. EXPLORE THE SYSTEM
Identify and prioritize potential partners for sustainability

4. PLAN PARTNER ENGAGEMENT
Develop an action plan to engage high-priority sustainability partners

5. CRAFT A DATA-DRIVEN PITCH
Develop compelling messages and use evidence to attract partners
Structure of Each Module

Each module is organized into four sections including key concepts and relevant exercises, examples, and templates to guide your team through each step in the sustainability planning process.

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<th>CONTENT</th>
<th>INTRODUCTION</th>
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<td>Context for how the module can support your team’s work on sustainability</td>
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<th>RESOURCES &amp; TOOLS</th>
<th>EXERCISE</th>
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<tbody>
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<td></td>
<td>Guidance on how to use a relevant tool to facilitate reflection and planning for your team</td>
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| EXAMPLE           | An example of a completed version of the tool from a health equity project |

| TEMPLATE          | A blank tool template for your team to complete                           |
Guidance For Using The Toolkit

• The tools are **best used with a group**.
  – These tools yield the strongest insights when they combine multiple perspectives.
  – They support teams in developing a common understanding of sustainability.
  – The group working with the toolkit should include the core team involved in planning and implementing the project. You may also choose to include other partners.

• Each tool takes **approximately 1.5 hours to complete** and discuss.

• We invite you to use the tools **that are most relevant to you**.
  – The tools **build on one another** and it can be helpful to use them in sequence, particularly if you are just beginning to plan for sustainability.
  – Using one tool (e.g., the Partner Action Plan) may make you want to revisit others (e.g., Sustainability Vision and Goals) – the tools are **interlinked**.
  – However, if you would prefer to use the tools à la carte, we encourage you to **start by identifying where you could use more support**. The next section includes a **self-assessment** to help you determine where to focus your efforts.

– These tools are intended to support iterative planning over time. We encourage you to **revisit the modules to refine your thinking** as your project progresses.
Introduction

Understand sustainability and how to approach sustainability planning
Why Plan for Sustainability?

Intentionally building sustainability strategies, activities, and partnerships into your work will help you achieve impact goals and support continuation of your program.

Example: A big sustainability challenge
An organization without a sustainability plan

• Consistently delivered a strong program and scaled the work to 12 new sites in multiple states over the course of a three-year grant

• Worked towards opportunities for sustainability on an ad-hoc basis, but primarily focused on delivering the program

• By the end of the grant, was unprepared to maintain the program across all sites and needed additional funding, but was unprepared because the organization:
  • Did not have a robust data collection approach, so had insufficient evidence of impact to deliver to donors
  • Had not established agreements with partner sites for sharing program costs beyond the initial grant, so partners were unwilling or unable to pay

Example: A sustainability success story
Marshall University Appalachian Diabetes Program

• Expanded the use of community health workers (CHWs) to improve diabetes care for underserved groups in the Appalachian region

• Built relationships with target communities to expand patient involvement in the program and discussed payment for CHWs with healthcare providers and payers from the outset, resulting in regular meetings with payers in the pilot project

• Collected clinical and population level data from the outset to prove the effectiveness and cost-saving capabilities of the model, which ultimately led insurance companies to offer enhanced reimbursements for CHWs

• Leveraged innovative funding models, such as impact investing, to explore avenues for underwriting long-term program costs in ways that suited the needs of key partners
Two Components of Sustainability

- Sustaining your work can have two equally important components, and you may aspire to one or both. Both components rely on partnership.

Deepen implementation of your program and secure ongoing resources
- Ensure patients, health systems, and other partners are willing and able to continue the work

Work with others to scale, expand, or replicate your program
- Pursue changes in policies, practices, or resources to reach more people with your program

- Improve the **effectiveness**, **comprehensiveness**, and **reach** of your project
- **Institutionalize effective practices/policies** within the organizations with which you are currently working
- **Secure sustained resources** for the project (e.g., from hospital budgets, community benefit, philanthropy, payers, or governments)

- Work with your organization or others to directly **replicate** the program in new communities and/or **expand** it to new disease areas (e.g., different cancer types)
- Support **dissemination and uptake of effective practices** from your program among relevant practitioners or policymakers
- Shift **public policy** to support effective practices (e.g., government funding for community health workers)
Possible Pathways for Sustainability

Pathways for achieving sustainability are varied. You may already be pursuing some, while others might be new. This toolkit will invite you to consider all of the pathways below as potential avenues for sustaining your program.

*Eight Pathways to Sustain Health Equity Work*

1. Building **community partner** buy-in to continue program implementation beyond allocated funding.
2. Influencing **clinical practice** (e.g., via continuing medical education)
3. Influencing **organizational or institutional policies** (e.g., instituting social determinants of health screening protocols, sustaining changes in referral processes)
4. Engaging **health system administrators** to reshape organizational resource allocation and funding flows
5. Securing additional **philanthropic funding**
6. Securing state and/or federal **government** grant funding
7. Working with **private and/or public payers** to change reimbursement eligibility
8. Conducting and disseminating **research** that captures effectiveness of a new intervention/approach to spur replication by others
To get started, complete the self-assessment provided below to identify which components of the toolkit will be most useful for you.

<table>
<thead>
<tr>
<th>Program Components</th>
<th>1. Which of these elements are part of your current program?</th>
<th>2. Of those, which elements do you need to sustain beyond current funding?</th>
<th>3. What are your initial ideas for how to sustain these elements? (see Slide 11 for list of sustainability pathways)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Community outreach and engagement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Prevention education/programming (e.g., smoking cessation)</td>
<td></td>
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<tr>
<td>c. Screening</td>
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<td></td>
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<tr>
<td>d. Patient navigation</td>
<td></td>
<td></td>
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<tr>
<td>e. Wrap-around support (e.g., transportation, housing, nutrition)</td>
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<tr>
<td>f. Linkage from testing to treatment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>g. Survivorship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Technical assistance or training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Other:</td>
<td></td>
<td></td>
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</tbody>
</table>
Sustainability Self-Assessment (2/2)

**Reflection Questions**

- How challenging was it to answer the self-assessment questions?
  If it was difficult, start with Toolkit **Modules 1 and 2**. They will provide a step-by-step process to clarify your sustainability vision and will help you establish sustainability goals.

- How challenging was it to answer Question 3 in the self-assessment?
  If it was difficult, then start with Toolkit **Module 3** and then work backwards to complete Modules 1 and 2. Module 3 will help you explore the system in which your organization operates and will help you identify potential partners for sustainability.

- How prepared are you/your organization to approach the types of sustainability partners you identified in response to Question 3?
  If you have clarified sustainability pathways and partners, but are uncertain how to move forward, then skip Toolkit Modules 1–3 and start with **Modules 4 and 5**. Together, these modules will help you plan for how to engage potential partners and will help guide decisions on the research, data collection, and evaluation evidence that can inform a compelling “pitch” for your program to potential partners.
Module 1

Develop a Sustainability Vision

*Define a long-term vision for your work beyond an individual grant*
INTRODUCTION
Develop a Sustainability Vision

Many programs have a vision for solving a specific problem, but do not include long-term aspirations for sustainability and scale.

A vision for sustainability articulates the change you hope to achieve beyond an individual grant.

This module will help you to:

- **Guide your work** during and after the grant period
- Ensure that sustainability is top of mind for your project team and a part of your project’s planned activities and measured outcomes
- Keep **internal stakeholders** on the same page about what the program is aiming to achieve—not only during the grant period, but also in the long term
- Communicate the value of your work to **potential partners and funders** and help them understand how they fit into your overarching goals
EXERCISE
Visioning (1/2)

An exercise (based on a method called Appreciative Inquiry) can help your team expand its vision to include long-term impact and sustainability.

The next two pages include instructions and prompts for completing the exercise.

Guidance on Completing the Exercise

1. Meet with your project team.

2. Individually reflect on the prompt (see next page) and consider the questions. Provide the “sustainability pathways” list (page 11) as a helpful thought starter. (10 minutes)

3. Ask people to share individual reflections. Ask all participants to speak in the present tense as if the future was now to help make the possibilities feel real. (30 minutes)

4. Discuss themes across the reflections and synthesize the key points into a 1-2 sentences as a guiding vision for sustainability. (30 minutes)

Note: If there are divergent points of view, consider which ideas seem the most viable given your internal or external context (e.g., existing assets, expertise, and networks, to the extent that the state healthcare policy environment is conducive to efforts to address health equity).
EXERCISE
Visioning (2/2)

Visioning Prompt and Reflection Questions

Imagine that it is the year 2025. You have just received the latest issue of *Health Affairs* and you see that the cover story is celebrating your work for improving patient outcomes by eliminating socio-economic, geographic, racial, and/or ethnic disparities in healthcare for serious, complex diseases.

On your way into work, you run into a colleague who mentions the *Health Affairs* cover story and you begin to talk about why you and your partners were so successful and **how you were able to sustain and scale the program’s impact** beyond the first grant.

Your colleague asks you several questions:

- What were the **most significant changes that enabled you to continue delivering your program** (e.g., changes in health systems, the types of reimbursements available to cover services, policy changes, greater community buy-in)?

- What contributed to **so many people being positively impacted** by the type of solution that you were implementing? How did you achieve such extensive reach?

- **Who** was critical to achieving sustainability of the program? What helped you be **effective** in engaging these partners (e.g., alignment on common goals, shared resources, data that “made the case” for the intervention, published research that demonstrated results)?
Example: A health system working to improve vulnerable populations’ access to specialty care for cardiovascular disease in Camden, New Jersey.

**Vision:**

All Camden, NJ residents with cardiovascular disease, especially those who are low income and vulnerable, will have health outcomes equal to or better than patients receiving specialty care in the surrounding region.

A definition of the scale and scope of the problem that you aim to solve

An ambitious goal requiring greater action beyond an individual program or initiative
Vision:

A definition of the scale and scope of the problem that you aim to solve

An ambitious goal requiring greater action beyond an individual program or initiative
Establish Sustainability Goals

Embed sustainability goals and activities in your project strategy
INTRODUCTION
Establishing Sustainability Goals

A logic model is a graphical depiction of your strategy with planned actions and goals. Embedding sustainability goals and activities into your logic model provides your team with a tangible plan that can keep you on-track and accountable to a set of sustainability goals.

This module will help you to:

- Develop a common **sustainability plan to guide your team and partners**
- Define **specific, proactive sustainability strategies** in addition to core program delivery
- **Identify new activities** that can contribute to your project’s sustainability
- **Track and evaluate** progress towards sustainability goals over time
- Communicate to funder(s) **how your work will continue** beyond their initial investment
Exercise
Updating Your Logic Model (1/2)

Note: This exercise assumes that you already have a logic model for your program and focuses on incorporating sustainability. If you have not yet created a logic model, and need support to do so, see the Additional Resources at the end of this toolkit.

Guidance on Completing the Exercise

1. Place your sustainability vision at the top of your logic model.
2. Translate elements from your sustainability vision to the long-term outcomes for your project. Long-term outcomes should include the health impact you hope to create and the sustainability, scale, and/or replicability of your work beyond the initial grant.
3. Working backwards from those long-term outcomes, add interim outcomes, short-term outcomes, activities, and inputs that will help you achieve the sustainability outcomes. Also note underlying assumptions related to achieving your sustainability outcomes.
   - Short-term outcomes may include the results of initial partner engagement and outreach (e.g., changes in knowledge or attitudes, indicators of participation/buy-in).
   - Interim outcomes may include changes in resources, practices, or policies that contribute to sustained impact.
   - Note: Sustainability outcomes will often require you to influence the context around your project, and you will not have as much control over them as you do for your program outcomes. That said, it is helpful to identify the changes you hope to see in the future.
4. Note questions that you will need to explore further before completing the logic model.
EXERCISE
Updating Your Logic Model (2/2)

VISION:
Ground your logic model in a guiding vision (see Module 1) for program success and sustainability

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Participation</td>
<td>Short-Term</td>
</tr>
<tr>
<td>Outputs</td>
<td>Outcomes</td>
<td></td>
</tr>
<tr>
<td>Inputs</td>
<td>Outline the resources that will allow your team to pursue sustainability activities (e.g., technology for collecting data, time and materials for engaging stakeholders)</td>
<td></td>
</tr>
<tr>
<td>Outputs</td>
<td>Include the sustainability activities and stakeholder participation outputs you would like to see (e.g., partnership-building efforts, awareness-building among stakeholders, increase in participating providers, changes to data systems)</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>Include the short-, medium-, and long-term outcomes you hope to see in realizing your sustainability vision. These outcomes should be changes you can influence through your sustainability activities (e.g., improvements in patient or provider experience, improvements in cost-effectiveness/efficiency, improvements in system performance, supportive policy or systems changes)</td>
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</table>

ASSUMPTIONS:
Capture the underlying beliefs, values, and assumptions that are necessary for your project to be sustained, scaled, or replicated (e.g., capacity of other stakeholders to adopt your model, applicability of model to other populations)
**EXAMPLE**

**Logic Model Incorporating Sustainability**

Example: A health system working to improve access to care for low-income residents with cardiovascular disease in Camden, NJ (Note: Sustainability-related updates below in blue).

**VISION:** All Camden, NJ residents with cardiovascular disease, especially those who are low income and vulnerable, will have health outcomes equal to or better than patients receiving specialty care in the surrounding region.

### Inputs
- Grant funding
- Staff
- Health system leadership
- Delivery models
- Collaboration with payers and social service agencies
- Research expertise

### Outputs

#### Activities
- Use screening tool to evaluate unmet social needs
- Develop complex care intervention for high-risk patients
- Partner with social service agencies
- Partner with payers
- Conduct research

#### Participation
- # of social needs screenings completed
- # of complex care visits completed
- # of social service agency partnerships made
- # of payer partnerships made
- # of publications from the program

### Outcomes

#### Short-Term
- Social needs screening tool piloted and finalized
- Increase in healthy behaviors
- Decrease smoking rates
- Collaborations with key social service resources
- Discussions with at least one payer on collaboration

#### Medium-Term
- Improved access to cardiovascular specialty care for Camden residents
- Decrease in emergency department and hospital utilization
- Developed and shared best practices on social needs screening and collaboration across health, payer, and social service sectors

#### Long-Term
- Decrease in cardiovascular (CV) morbidity and mortality
- Social needs screenings and referrals uniformly integrated across health system
- Health system becomes national leader on social needs screening, multi-sector collaboration, and improving access to CV specialty care

**ASSUMPTIONS:**
- Patients who have a higher number of social needs have worse health outcomes
- Addressing social needs will improve health outcomes
### VISION:

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Participation</td>
<td>Short-Term</td>
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</tbody>
</table>

### ASSUMPTIONS:
Explore the System

Identify and prioritize potential partners for sustainability
Exploring the System

Systems mapping is a method for considering the actors and factors influencing your project so you can identify new points of leverage to deepen and expand your work.

Following a revision to your vision and logic model, systems mapping can be a useful way to consider new types of actors that may be relevant for sustaining your work. This exercise may also prompt you to refine your vision or logic model.

This module will provide insights across three dimensions:

- **Context**
  - Understand the larger environment around your work and the problem you are addressing
  - Illuminate factors affecting your target population

- **Partners**
  - Provide a digestible representation of the communities, sectors, and organizations relevant to your project
  - Highlight other actors working towards common goals
  - Identify actors with the power to advance your work who have not yet been engaged

- **Impact**
  - Recognize blocks or gaps in the system that could limit the effectiveness of your work
  - Identify new opportunities for sustainability and prioritize among potential partnerships
EXERCISE
Systems Mapping

Step 1
Place the patient (or other population your work aims to benefit) at the core of map

Step 2
Identify all actors that are, or could be, relevant to the implementation and sustainability of your project. Start by adding actors in the inner rings that the target population interacts with most frequently. Then add actors in the outer rings that influence those in the inner rings—these may include philanthropies, professional associations, government agencies, or others. Be practical, yet ambitious when adding to the map.

Step 3
Define groups of actors that make up particular sub-systems, sectors, or types (see sample sub-systems at right)

Step 4
Identify connections between actors and between you and other actors (use thin or dotted lines for weak connections, and thick lines for strong connections)

Step 5
Use the map to discuss connections that could be created or strengthened to foster sustainability

Sub-systems relevant for health

Healthcare Systems and Providers
(e.g., community clinics, private practice)

Public and Private Payers
(e.g., Medicare, state Medicaid agencies, private insurers)

Private Sector
(e.g., employers, pharmacies, grocery stores, tech companies)

Community Infrastructure
(e.g., transportation, housing, parks, schools)

Government
(e.g., city councils, health departments, county, state & federal agencies)

Community Organizations
(e.g., faith-based orgs, task forces & coalitions, service providers)
DISCUSSION QUESTIONS
Systems Mapping

After the systems mapping activity, discuss the following questions with your group:

• Overall, what do you see? What did the systems mapping activity reveal about the context in which you are working and the sustainability pathways you hope to pursue?

• What opportunities did your map illuminate to make progress towards your sustainability vision and strategy?
  - Are there additional actors working to achieve a shared goal that you could partner with to deepen implementation of your project? [Note: They may be closer to the center of your map]
  - Are there additional actors you can engage early on to build relationships and support for sustaining your work over the long term? [Note: They may be closer to the outside of your map]
  - Are there opportunities for disseminating your work to broader audiences that you may not currently be pursuing (e.g., public meetings, professional associations, other related organizations)?
  - To what extent do the opportunities you identified have a time dimension? Which opportunities are best pursued in the short-, medium-, or long-term? Are there any that it might be helpful to pursue sooner than you originally thought?
Example: Maryland health system working to improve lung cancer screening and linkage to care

Through this exercise, the health system recognized major local employers as potential partners for smoking cessation.
Plan Partner Engagement

Develop an action plan to engage high-priority sustainability partners
INTRODUCTION
Planning for Partner Engagement

While partnerships require flexibility, a clear plan to support effective partnership-building efforts can advance your sustainability goals.

A partner action plan defines the “who,” “what,” “how,” and “why” of partner engagement. It is a tool to help you prioritize potential partners, identify shared goals, and coordinate your team to engage partners.

This module will help you to:

- Clearly define shared goals around which you can engage potential partners
- Surface questions to ask potential partners to understand their potential interest in your work
- Define the roles you hope potential partners will play in your work
- Provide your team with concrete ideas for engaging partners and building relationships over time
- Provide the team with a shared plan that you can revisit periodically to track progress and maintain momentum while you are in the midst of day-to-day implementation
INTRODUCTION

Partner Roles

Partners can play a wide variety of roles in either deepening the implementation of your project or working with you to scale, expand, or replicate the project.

As you consider partners’ roles, it is important to consider each partners’ unique interests, priorities, networks, and capabilities.

<table>
<thead>
<tr>
<th>Illustrative Partner Roles</th>
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<tbody>
<tr>
<td>Deepen implementation</td>
</tr>
<tr>
<td>• Help establish deeper connections with your target community</td>
</tr>
<tr>
<td>• Provide a service your target population needs but your organization cannot provide</td>
</tr>
<tr>
<td>• Share guidance on your project’s strategies, metrics, and progress</td>
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<tr>
<td>• Coordinate data collection to demonstrate the impact of your work (e.g., on health outcomes, patient satisfaction, cost efficiency) in ways that also advance their goals</td>
</tr>
<tr>
<td>• Align efforts across organizations to create a mutually reinforcing approach to achieving ambitious health equity goals that would be difficult for each organization to achieve alone</td>
</tr>
<tr>
<td>• Leverage their influence to encourage behavior change among relevant practitioners</td>
</tr>
</tbody>
</table>
INTRODUCTION
Partnership Levels (1/2)

In addition to identifying partner roles, it is also helpful to consider the depth at which to work with partners at various stages of the project to build engagement and motivate action. Below are four levels of partnership that you could employ across partners.

### Levels of Partner Engagement

<table>
<thead>
<tr>
<th>How</th>
<th>What Illustrative</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inform</strong></td>
<td>Alert potential partners about the existence, progress, and successes of your program</td>
<td>Increase awareness of your work</td>
</tr>
<tr>
<td></td>
<td>Request guidance from partners on project goals, strategies, processes, and/or metrics</td>
<td>Add experienced insight to your work and build buy in</td>
</tr>
<tr>
<td><strong>Consult</strong></td>
<td>Work with partners on mutually reinforcing activities</td>
<td>Achieve greater progress towards objectives by deepening implementation and expanding buy-in among key stakeholders</td>
</tr>
<tr>
<td></td>
<td>Bring partners into your work as joint decision-makers</td>
<td>Embed additional perspectives into all aspects of your project and build ownership for the work among partners</td>
</tr>
</tbody>
</table>

Source: Adapted from Tamarack Institute Community Engagement Continuum
INTRODUCTION
Partnership Levels (2/2)

Examples across levels of partner engagement

**Inform**

CancerCare convened diverse stakeholders (e.g., patient advocates, health plans, government agencies, foundations) at the outset of a project to strengthen disaster preparedness planning for cancer treatment to build awareness of the project and gauge interest in additional engagement.

**Consult**

The University of Illinois Cancer Center builds lasting relationships with community organizations and local business owners to expand the reach of its prevention and screening programs by sharing health outcomes data, holding community meetings, and participating in community events.

**Involve**

West Virginia University Cancer Institute consulted with health systems leaders early on in its implementation of a cancer survivorship program on their priority metrics to inform its own evaluation approach in a way that was aligned to the health system’s goals and targets.

**Co-Lead**

Maine Medical Center co-leads the Maine Lung Cancer Coalition, where it regularly engages funders, patient advocate organizations, and health systems as partners, sharing data, jointly identifying funding opportunities, and collaborating on leadership decisions.
Consider your sustainability goals and the actors that would be most important for moving them forward (these actors may currently be central to your work or more peripheral).

For the partners that seem most important to achieving your goals, fill out the table below with your team.

<table>
<thead>
<tr>
<th>Potential Partners</th>
<th>Shared goal that will prompt engagement</th>
<th>Current relationship</th>
<th>Desired Level of Engagement and Specific Ask</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Year One</td>
</tr>
<tr>
<td>1. Specify why this partnership makes sense for both your and your partner’s work (e.g., “both working to reduce asthma disparities in New England”)</td>
<td>2. Indicate your current relationship with the partner (e.g., “no relationship,” “met once at conference,” “meet monthly”)</td>
<td>3. Identify your ideal level and type of engagement with the partner at different stages of your grant (e.g., “Inform – send them our brief,” “Involve – invite to join Steering Committee”)</td>
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</tbody>
</table>
## Partner Action Plan

Example: Collaboration between a university cancer center, local cancer registry, and nonprofit research center on a patient navigation program for Asian Americans in Northern California

<table>
<thead>
<tr>
<th>Potential partners</th>
<th>Shared goals</th>
<th>Current relationship</th>
<th>Desired level of engagement and specific asks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shanti</strong></td>
<td>Cancer navigation</td>
<td>Member of Patient Advisory Committee, collaborator on other projects</td>
<td>Year one: Inform; Consult on navigation; Year two: Inform; Consult; Involve in web portal development; Year three: Involve; Co-lead to disseminate and test web portal</td>
</tr>
<tr>
<td><strong>Eureka</strong></td>
<td>Leveraging technology for healthcare</td>
<td>Technology partner for web portal development</td>
<td>Year one: Involve in web portal development; Year two: Involve in web portal development/maintenance; Year three: Involve; Explore potential to co-lead</td>
</tr>
<tr>
<td><strong>California Pacific Medical Center</strong></td>
<td>Patient care in San Francisco</td>
<td>Collaborator on other projects</td>
<td>Year one: Inform; Year two: Consult for feedback on web portal; Year three: Involve in dissemination of web portal</td>
</tr>
<tr>
<td><strong>San Francisco Cancer Initiative</strong></td>
<td>Reduce the burden of cancer in San Francisco</td>
<td>Collaborator on other projects</td>
<td>Year one: Inform; Year two: Consult for feedback on web portal; Year three: Involve in dissemination of web portal</td>
</tr>
<tr>
<td><strong>Curesoft</strong></td>
<td>Leveraging technology for navigation</td>
<td>Member of Patient Advisory Committee</td>
<td>Year one: Inform and consult (via Patient Advisory Committee); Year two: Inform and consult (via Patient Advisory Committee); Year three: Involve in dissemination of web portal; additional projects</td>
</tr>
<tr>
<td>Potential partners</td>
<td>Shared goals</td>
<td>Current relationship</td>
<td>Desired level of engagement and specific asks</td>
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</table>
Craft a Data-Driven Pitch

Develop compelling messages and use evidence to attract partners
Crafting a Data-Driven Pitch

Crafting an effective pitch involves speaking to partners’ unique interests and priorities. Identifying key elements of your story early provides time to plan for, collect, and use relevant data from a variety of sources to establish narratives to influence partners.

This module will help you to:

- Engage multiple partners across a variety of sectors in ways that are uniquely relevant to them
- Refine your evaluation plan in light of your sustainability goals
- Identify additional sources of data beyond your project’s M&E that will help provide a holistic view of your project’s progress and impact

Note: Every project has valuable data, even projects that have not yet started. If you are early in your work, you can use data to highlight the needs your project is meeting, estimate the health impacts you anticipate having, compare your anticipated impact with that of other, similar efforts, and relate your goals to particular partners’ priorities (e.g., health equity, systems transformation, quality and satisfaction, cost effectiveness). See page 45 for more ideas.
INTRODUCTION
Elements of a Strong Pitch

There are three steps to constructing a data-driven pitch.

---

**DEFINE YOUR VALUE PROPOSITION**
Consider the motivations of potential partners based on their contexts (e.g., industry; geographies of interest; past work) and identify the key ways your project addresses their priorities.

---

**CRAFT A COMPELLING NARRATIVE**
Craft a series of messages that will be compelling and motivating to specific high-priority partners.

---

**IDENTIFY AND GATHER SUPPORTING DATA**
Determine the data needed (from multiple sources) to support your key messages, and develop a plan for gathering it, including data sources, necessary resources, and timeline.

See the *Appendix for resources* on identifying the motivations and data interests of common types of partners: healthcare, government, philanthropy, and payer organizations.
The “Triple Aim” of Healthcare

- The Triple Aim framework is commonly used by health systems, policymakers and payers.
- It highlights three common aims of healthcare programs, although some have added a fourth aim around health equity or provider experience.
- Aligning the value proposition of your program to this framework will help you make the case for your work with key sustainability partners.
- The case for sustaining or replicating your program will be strengthened if you can develop and share evidence across multiple elements within the “Triple Aim” framework.
- For financial return calculations, a time horizon of one to three years is reasonable.

Source: Adapted from the Institute for Healthcare Improvement’s Triple Aim Framework. See detailed guide for additional information.
INTRODUCTION
Craft a Compelling Narrative

A compelling narrative about your program addresses the need for and impact of your work, as well as your resource/partnership aspirations—from your audiences' perspective.

Below is a sample outline for partner engagement materials to share this narrative.

1. **Introduction to the program and its impact (common for all audiences)**
   - Health problem the program is addressing, the current implications of the problem for patients, and impacts at the local, state, and/or federal levels (e.g., number of people affected; costs to the system; economic implications)
   - Drivers of the problem (e.g., financing, complexities with navigating the system, effect of social needs on access to care)
   - Anticipated scale or depth of the benefit to patients if this problem were addressed
   - How the program addresses these health problems
   - Components/key features of the program

2. **Early results of the program (tailored to value proposition for each audience).** These could include:
   - Improvements related to the Triple Aim (e.g., health outcomes and equity, healthcare quality, cost-effectiveness, operational effectiveness, patient satisfaction/retention, provider satisfaction/retention, provider use of time, revenue)
   - Improvements to community-level coordination and/or mobilization of community resources
   - Benefits to the local, state, or federal health system (e.g., quality, cost-effectiveness, reach)

3. **Vision for sustainability (i.e., aspirations for deeper implementation, scaling, or replication)**
   - Additional problems program stakeholders seek to address (e.g., application of the program to the needs of additional populations, other health problems, or other parts of the health system)
   - Why this program model is a good fit for addressing these problems
   - Anticipated scale/impact of benefits if this additional problem were addressed (tailored to each audience)

4. **What is needed to reach vision for sustainability (tailored to each audience)**
   - A specific need/ask—or a “menu” of needs/asks—that illustrates how the potential partner can support your work
If you are early in your project, you likely will not have progress or outcomes data to use. However, you can draw on a number of other types of data to speak to the need for your program and its anticipated benefits.

### Types of Data

<table>
<thead>
<tr>
<th>Types of Data</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local demographic and health data (e.g., on disease incidence, rates of smoking) illustrating need for the program</td>
<td>• National Minority Quality Forum Indices with zip code level data on health inequities</td>
</tr>
<tr>
<td>• Evidence that illustrates the impact of addressing health problems (e.g., on health outcomes, cost, productivity)</td>
<td>• Reports or data from local health departments</td>
</tr>
<tr>
<td>• Case studies and data from similar programs or interventions that illustrate the outcomes you hope to achieve</td>
<td>• Data from private payers (CompareMaine)</td>
</tr>
<tr>
<td>• Qualitative data sharing stories or perspectives from individual patients that show the need for the program in real life</td>
<td>• Health systems’ Community Health Needs Assessments</td>
</tr>
<tr>
<td>• Data from the partner to illustrate potential implications for them (e.g., cost data or revenue generating data)</td>
<td>• Evaluations from similar efforts</td>
</tr>
<tr>
<td>• Qualitative data sharing stories or perspectives from individual patients that show the need for the program in real life</td>
<td>• Academic studies based in your target geographical area, or relevant to your target population</td>
</tr>
<tr>
<td>• Data from the partner to illustrate potential implications for them (e.g., cost data or revenue generating data)</td>
<td>• Interviews and focus groups with intended beneficiaries</td>
</tr>
<tr>
<td>• Qualitative data sharing stories or perspectives from individual patients that show the need for the program in real life</td>
<td>• Claims or payments data from local government departments or private payers</td>
</tr>
<tr>
<td>• Data from the partner to illustrate potential implications for them (e.g., cost data or revenue generating data)</td>
<td>• Referrals (and associated revenue) generated due to project</td>
</tr>
</tbody>
</table>
If you have been implementing for a while, you can complement project progress or outcomes data with additional data illustrating the systems impact and potential future benefits of the program, particularly if sustained and/or scaled.

<table>
<thead>
<tr>
<th>Types of Data</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Program data on the progress, reach, and health impacts</strong> of the project, from your monitoring and evaluation efforts</td>
<td>• <strong>Service provision data</strong> from internal databases</td>
</tr>
<tr>
<td>• <strong>Calculations of financial return on investment</strong> tailored to partner audiences (e.g., health systems, payers, government agencies)</td>
<td>• <strong>Clinical outcomes data</strong> from internal databases</td>
</tr>
<tr>
<td>• Qualitative data sharing <strong>stories or perspectives from individuals</strong> that illustrate the impact of your work on the patient experience and potentially on patients’ lives</td>
<td>• <strong>Results of surveys, interviews, focus groups</strong>, and other evaluation methods</td>
</tr>
<tr>
<td>• Comments on the value of the program <strong>from the perspective of other actors whose views are important to the partner</strong> (e.g., views of staff physicians for an audience of health systems leadership)</td>
<td>• <strong>Data from health systems, payers or government agencies</strong> to support return-on-investment calculations</td>
</tr>
<tr>
<td>• <strong>Letters of support</strong> from project stakeholders</td>
<td>• <strong>Interviews and focus groups</strong> with participating patients and/or providers</td>
</tr>
<tr>
<td>• <strong>Interviews</strong> with project partners</td>
<td>• Letters of support from project stakeholders</td>
</tr>
</tbody>
</table>
EXERCISE
Build a Data Plan

Focusing on your partnership aspirations, consider the motivations of potential partners and the types of messages and supporting data they would find most compelling. Fill out the table below with your team.

<table>
<thead>
<tr>
<th>Potential partner</th>
<th>Motivations of partner</th>
<th>Compelling data for partner</th>
<th>Data sources</th>
<th>Plan and timeline for accessing data</th>
</tr>
</thead>
<tbody>
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Specify why this partnership makes sense for your partners’ work*
(e.g., “both working to reduce asthma disparities in New England”)

*If you have created a partner action plan, you may copy the responses from that sheet here

Describe what types of data speak to this partner
(e.g., “quantitative analysis of cost savings,” “evidence of need”)

Identify where you might gain access to this data and note where new data will need to be collected
(e.g., “research from local and state departments”)

Briefly describe your plan and timing for gathering and sharing data with the partner
(e.g., “conduct cost savings estimation of project and meet with State Health Department by third month of grant”)

**Recommended Discussion Questions**

1. What **additional information** do we need in order to understand the motivations of our potential partners?
2. If we currently have access to the data that our current or potential partners would find compelling, what is our **plan for synthesizing and sharing this data** with the partner?
3. If we do not currently have data we want, what **steps can we take** to create or access this data?
Example: A Philadelphia health system that is engaging a learning community dedicated to reducing lung cancer stigma and other barriers to care and to increasing lung cancer prevention and control, especially among the city’s most vulnerable residents.

**Vision:**
Serve Philadelphia’s uninsured and underinsured populations by providing greater access to LDCT (low dose computerized tomography) screening

<table>
<thead>
<tr>
<th>Potential Partner</th>
<th>Motivations of partner</th>
<th>Compelling data for partner</th>
<th>Data sources</th>
<th>Plan and timeline for accessing data</th>
</tr>
</thead>
</table>
| Center for Urban Health            | To improve the health and well-being of Philadelphia’s residents | • Report on the increase in survivorship when early screening is undertaken  
• Results from New Jersey effort to provide greater access to LDCT screening | • Health academic journals  
• Reports from the American Lung Association | • Begin compiling evidence in week one, month one of the project  
• Develop key takeaways to share with potential partners by week two, month two |
| Independence Blue Cross (IBC)     | Serve the health insurance needs of Philadelphia and southeastern Philadelphia | • Research on decreased insurance costs when lung cancer screening is readily available  
• Projections on savings for IBC | • Team financial analysis  
• Reports from the National Cancer Institute | • Begin compiling research week one, month one, complete by week one, month two  
• Begin financial projections week one, month two, finish projections by week four, month three |
## Vision:

<table>
<thead>
<tr>
<th>Potential Partner</th>
<th>Motivations of partner</th>
<th>Compelling data for partner</th>
<th>Data sources</th>
<th>Plan and timeline for accessing data</th>
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Example: The National Center for Medical-legal Partnerships uses different types of data to articulate its value proposition to different audiences.

- Illustrating the need
- Noting impacts and benefits for providers
- Highlighting quotes from credible experts

**Providing evidence of cost savings and patient impacts**

Clinicians have a positive view MLP services.

In our 2016 survey of medical-legal partnership programs across the country, we asked healthcare organizations to tell us how often clinicians at their hospital or health center anecdotally reported the following benefits of MLP services:

- 86% reported improved health outcomes for patients;
- 64% reported improved patient compliance with medical treatment; and
- 38% reported improved ability to perform “at the top of their license.”

**Studying show that when legal expertise and services are used to address social needs:**

- People with chronic illnesses are admitted to the hospital less frequently. Studies showed that legal assistance targeted at improving housing conditions improved the health of asthma patients (Journal of Asthma and Journal of Health, the Poor and Underserved), and another study showed medical-legal partnerships' positive impact on the health of sickle cell patients (Pediatrics).
- Less money is spent on health care services for the people who would otherwise frequently go to the hospital, and use of preventative health care increases. A study showed that MLP services reduce health care spending on high-need, high-cost patients (Health Affairs), and a randomized control trial found families of healthy newborns increased use of preventive health care after MLP services (Pediatrics).
- Clinical services are more frequently reimbursed by public and private payers. Medical-legal partnerships have been shown to save patients health care costs and recover cash benefits (Journal of Health Care for the Poor and Underserved and Journal of Palliative Medicine).
Additional Resources

- Other sustainability resources
- Context for understanding the motivations and interests of potential partners
## Additional Resources

Below is a collection of additional resources and tools on a variety of topics that you may find valuable for pursuing sustainability.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic model development</td>
<td>W.K. Kellogg Foundation Logic Model Development Guide</td>
</tr>
<tr>
<td>Sustainable financing models</td>
<td>Beyond the Grant: A Sustainable Financing Workbook by ReThink Health</td>
</tr>
<tr>
<td></td>
<td><a href="https://www.rethinkhealth.org/financingworkbook/">https://www.rethinkhealth.org/financingworkbook/</a></td>
</tr>
<tr>
<td>Philanthropic funding</td>
<td>Foundation Center – “Offers data sources, publications and trainings focused on the philanthropic sector”</td>
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<tr>
<td></td>
<td><a href="fconline.foundationcenter.org/">fconline.foundationcenter.org/</a></td>
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<td>Foundation Stats</td>
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<td>Foundation Maps</td>
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<td><a href="https://maps.foundationcenter.org/home.php">https://maps.foundationcenter.org/home.php</a></td>
</tr>
<tr>
<td>Government funding</td>
<td>Grantspace: Where can I find information about government grants?</td>
</tr>
<tr>
<td></td>
<td><a href="grantspace.org/resources/knowledge-base/government-grants/">grantspace.org/resources/knowledge-base/government-grants/</a></td>
</tr>
<tr>
<td>Community health data</td>
<td>Community Commons – “We provide public access to thousands of meaningful data layers that allow mapping and reporting capabilities so you can thoroughly explore community health.”</td>
</tr>
<tr>
<td></td>
<td><a href="www.communitycommons.org">www.communitycommons.org</a></td>
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<tr>
<td>Communications</td>
<td>Cause Communications: Communications Toolkit</td>
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<tr>
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<td><a href="www.causecommunications.org/communications-toolkit">www.causecommunications.org/communications-toolkit</a></td>
</tr>
<tr>
<td>Community engagement and equity</td>
<td>Tools to Engage: Resources for Nonprofits, Compiled by the Building Movement Project – “An interactive, multi-level search portal that connects people and organizations looking to align the values and principles of their work to the best tools, research, and resources from across the social sector.”</td>
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<tr>
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<td><a href="tools2engage.org/">tools2engage.org/</a></td>
</tr>
</tbody>
</table>
To support you in partner action planning and crafting a data-driven pitch, the following pages contain information on the motivations and data interests of common types of partners: healthcare systems, government, philanthropy, and payer organizations.
HEALTHCARE SYSTEMS
Partner Types

System administrators are in an important position to change institutional policies and practices in ways that can catalyze and scale your work. Aligning your work to priorities identified in a Community Health Needs Assessment and to the Quadruple Aim will be compelling for this audience.

Community benefit departments have great potential for partnerships as they have an imperative to invest in the community and can provide grant funding. Aligning your work to priorities in the Community Health Needs Assessment will be critical to gaining their support.

Dignity Health is a large health system with over 39 hospitals in Western states

- Dignity Health hosts the Coordinated Community Network Initiative (CCNI), which electronically links healthcare providers to organizations that provide community services
- Dignity Health began piloting CCNI in Nevada in 2016. Starting in 2017, Dignity Health began replicating the initiative at 17 additional sites
- Among the sites operating CCNI, 4,200+ referrals have been made to 240 programs
- Dignity Health aims to scale the program to all 34 of its hospitals by 2020, and to continue to improve the platform to enable better outcomes tracking

Kaiser Permanente is a leading healthcare system that provides both insurance and care. Its Community Health program aims to:

- Ensure health access by providing individuals served by Kaiser Permanente or safety-net partners with integrated clinical and social services
- Improve conditions for health and equity by engaging members, communities, KP’s workforce, and all of the organization’s assets
- Advance the future of community health by innovating with technology and social solutions

Community Health provided more than $151 in grants in 2018

Note: Integrated health systems such as Kaiser Permanente are particularly interested in health equity innovations.
## Motivations

<table>
<thead>
<tr>
<th>PRIMARY MOTIVATION</th>
<th>System Admin.</th>
<th>Comm. Benefit</th>
<th>RELEVANT DATA</th>
</tr>
</thead>
</table>
| Improve health outcomes for patients and the surrounding communities               | X             | X             | • Data-driven assessment of underlying drivers of health inequity  
• Quantitative assessment of health and cost impacts of SDOH  
• Comparison of target group health outcomes and healthcare costs relative to population |
| Reduce non-reimbursed expenses                                                     | X             |               | • Assessment of current non-reimbursed expenses and ability of program to reduce them (e.g., reduce hospital readmissions for uninsured patients)  |
| Increase number of patients entering system for screening, diagnosis, and care     | X             |               | • Assessment of number of insured patients that are not accessing required healthcare  
• Assessment of number of patients receiving late diagnosis that could have been prevented with earlier outreach |
| Elevate reputation of health system                                               | X             | X             | • Ability to publish results, share program nationally and/or with specific relevant audiences or conferences                                  |
| Meet community benefit requirements                                               |               | X             | • Assessment of opportunities to help health system conduct community needs assessment and/or meet community benefit obligations |
| Aid provider operations and satisfaction                                           | X             |               | • Evidence that interventions are optimizing processes in ways that save providers’ time or effort  
• Data that interventions increase provider job satisfaction                       |
GOVERNMENT
Partner Types

Government partners can connect your program to communities of interest, provide robust data to support stages of your work, and/or open access to significant sources of funding.

There are three main levels of government to consider:

**Local/Municipal (e.g., local health departments)**
- Tend to focus on county-, city-, or neighborhood-level issues
- Not likely to provide direct grant funding, but can partner directly on services and facilitate access to specific communities or community-specific data
- Respond well to efforts that align with or leverage their existing work

**State Government (e.g., state health departments)**
- Focus on issues relevant to states’ specific social and policy context
- May provide direct funding and are well-positioned to scale successful efforts
- Have interest in efforts that can reduce or contain state costs while responding to an issue of constituent interest

**Federal (e.g., NIH/NCI, CDC, HRSA, CMMI)**
- Often focus on cutting-edge programs that can advance a field and/or issue
- Different agencies have different specializations—some focus on research, others on scaling programs to improve population health
- Can supply significant funding for efforts and incentives to support scaling
# GOVERNMENT Motivations

<table>
<thead>
<tr>
<th>PRIMARY MOTIVATION</th>
<th>Local</th>
<th>State</th>
<th>Federal</th>
<th>RELEVANT DATA</th>
</tr>
</thead>
</table>
| Improve healthcare and public health processes and public outcomes                 | X     | X     | X       | • Quantitative assessment of **health and cost impacts of SDOH**  
• Deep **understanding of patient processes** and barriers to care  
• **Narratives** that reflect the benefit of an intervention to constituents   |
| Address health disparities and promote health equity                               | X     | X     | X       | • **Milestones data** that demonstrates **concrete progress** within timelines that are responsive to political shifts (e.g., election cycles)  
• **Data-driven assessment** of underlying drivers of health inequity   |
| Contain or reduce costs                                                            | X     | X     | X       | • Thorough cost analysis to **pinpoint specific savings**  
• Detailed description of how an intervention **reduces downstream patient costs** |
| Encourage public-private partnerships with corporate and/or philanthropic actors   |       |       | X       | • **Strong potential partnerships or current partnerships** with a diverse range of entities  
• **Demonstrated history** of public-private partnership                        |
| Respond to issues of constituent interest                                          | X     | X     |         | • **Evidence of public interest** in a program’s goals and/or outcomes  
• Clear **relationship to a government focus** and/or area of interest  
• **Narratives** that reflect the benefit of an intervention to constituents  |
Philotropic capital can be very useful in catalyzing innovation, demonstrating the impact of unproven pilot programs, and providing the seed funding to test and scale interventions that are not yet verifiable.

There are several types of philanthropic funders:

**Health-Focused Funders (e.g., National or State Private Foundations)**
- Tend to be larger and focused specifically on health and health equity issues
- Grant making often focuses on proactive and cutting-edge initiatives
- Respond well to ambitious and well-researched efforts

**Corporate Philanthropies (e.g., Pharmaceutical and Insurance Companies)**
- Larger and focused on issues related to core areas of the business (e.g., pharmaceutical companies focus on disease-specific areas)
- Grant making may occur on a regular cycle
- Respond well to projects that clearly align with their business interests

**Local Funders (e.g., community foundations, local family foundations)**
- Tend to be smaller and focused on place-based issues
- Grants are made in response to community challenges
- Respond well to data that demonstrates how a project or program will improve the community issue of their interest
PHILANTHROPIC FUNDERS

Examples

**Health Focused Funder**

To build a culture of health and health equity for all communities, Robert Wood Johnson Foundation employs a four-pronged action framework:

- Making health a shared value
- Fostering cross-sector collaboration to improve well-being
- Creating healthier, more equitable communities
- Strengthening integration of health services and systems

**Corporate Philanthropy**

Aetna Foundation encourages healthy lifestyles and improves health among the underserved by:

- Partnering with national and select international organizations to bring innovative efforts to the world
- Coordinating with national partners to use research, experimentation, and education to reduce health inequities
- Providing grants to U.S. nonprofits to support interventions that inspire healthier lifestyles across communities

**Local Funder**

The Greater Washington Community Foundation supports the Washington area by:

- Mobilizing local philanthropy to support initiatives that support a diverse range of issues
- Lending strategic knowledge to the area’s nonprofits and donors to create a robust community sector
- Convening local leaders across an array of industries to support collaboration with a goal of local systems change
## PHILANTHROPIC FUNDERS
### Motivations

<table>
<thead>
<tr>
<th>PRIMARY MOTIVATION</th>
<th>Health Focused</th>
<th>Corporate</th>
<th>Local</th>
<th>RELEVANT DATA</th>
</tr>
</thead>
</table>
| Advance health equity by piloting ways to address the social determinants of health | X              | X         | X     | • Data-driven assessment of underlying drivers of health inequity  
• Quantitative assessment of health and cost impacts of SDOH  
• Comparison of target group health outcomes and healthcare costs relative to population |
| Address the needs of target demographic groups or disease areas                    | X              | X         | X     | • Traditional health, quality, and demographic indicators and outcomes  
• Comparison of target group health outcomes and healthcare costs relative to population |
| Support cross-sector collaboration                                                   | X              |           | X     | • Demonstrated instances of collaboration (e.g., existence of common agenda)  
• Map of mutually reinforcing activities and/or opportunities for collaboration     |
| Respond to local needs                                                              |                |           | X     | • Traditional health, quality, and demographic indicators and outcomes  
• Evidence of target health priority relative to other local needs (e.g., health impact on education outcomes) |
| Foster systems change                                                               | X              |           | X     | • Assessment of local policy environment and assessment of opportunities to scale and/or replicate program approach |
PARTNERS

Partner Types

Public payers can be key partners in creating changes in clinical practice and in driving uptake of changes by providing infrastructure that bridges systems of care. Start by identifying and approaching the largest Medicaid providers in your state.

Private payers can be key partners for accessing data, leveraging their networks, and sustainably funding program costs (e.g., making expenses reimbursable). Work in partnership with a health system and start by approaching the state health plans of major private payers.

HealthPartners Plans

HealthPartners Plans, a Medicaid MCO in Pennsylvania, partnered with the Metropolitan Area Neighborhood Nutrition Alliance (MANNA) to:

- “Prescribe” food and nutrition to medically vulnerable patients struggling with food insecurity
- Prepare and deliver 21 frozen meals a week to clients’ homes

By delivering over 470K meals to more than 1,858 medically vulnerable members, the effort has decreased HbA1c scores of diabetic members by 26% and reduced medical costs by 27%

Cigna uses a distinct approach in each community, depending on the health issues particular to the region. In Memphis, TN, Cigna used GIS mapping and claims data to:

- Identify a community that had a particularly high incidence of breast cancer
- Disaggregate the data to see that African American women in that community had lower rates of screening compared to white women
- Partner with churches and a Methodist hospital to communicate the importance and “how-to” of screening to the community
## Payers

### Partner Types

<table>
<thead>
<tr>
<th>PRIMARY MOTIVATION</th>
<th>Public Payers</th>
<th>Private Payers</th>
<th>RELEVANT DATA</th>
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</table>
| Improve Medicaid/Medicare patient health outcomes, experience, and access to services | X | | • Data-driven assessment of underlying **drivers of health inequity**  
• Quantitative assessment of **health and cost impacts of SDOH**  
• Comparison of target group health **outcomes and healthcare costs relative to population** |
| Increase member satisfaction and loyalty | | X | • Evidence of program (or analogous programs) resulting in patient satisfaction and/or improved patient experience  
• Evidence of program (or analogous programs) resulting in provider job satisfaction, time savings, or other dimension |
| Reduce costs, especially related to high-cost patients | X | X | • Data-driven assessment of underlying **drivers of health inequity**  
• Quantitative assessment of **health and cost impacts of SDOH**  
• **Claims data** for high-cost patients, including services provided, cost, and location  
• Expected or actual **cost of program** (e.g., to estimate return on investment)  
• Expected or actual time to impact (e.g., to estimate likely cost savings) |
| Build the case for key priorities (e.g., policy change, SDOH) | X | | • Assessment of **local policy environment** and assessment of opportunities to scale and/or replicate a program or approach |
| Demonstrate the case for SDOH pilots and improve community heath | | X | • **Ability of program to be scaled / replicated** across communities in which the payer operates |