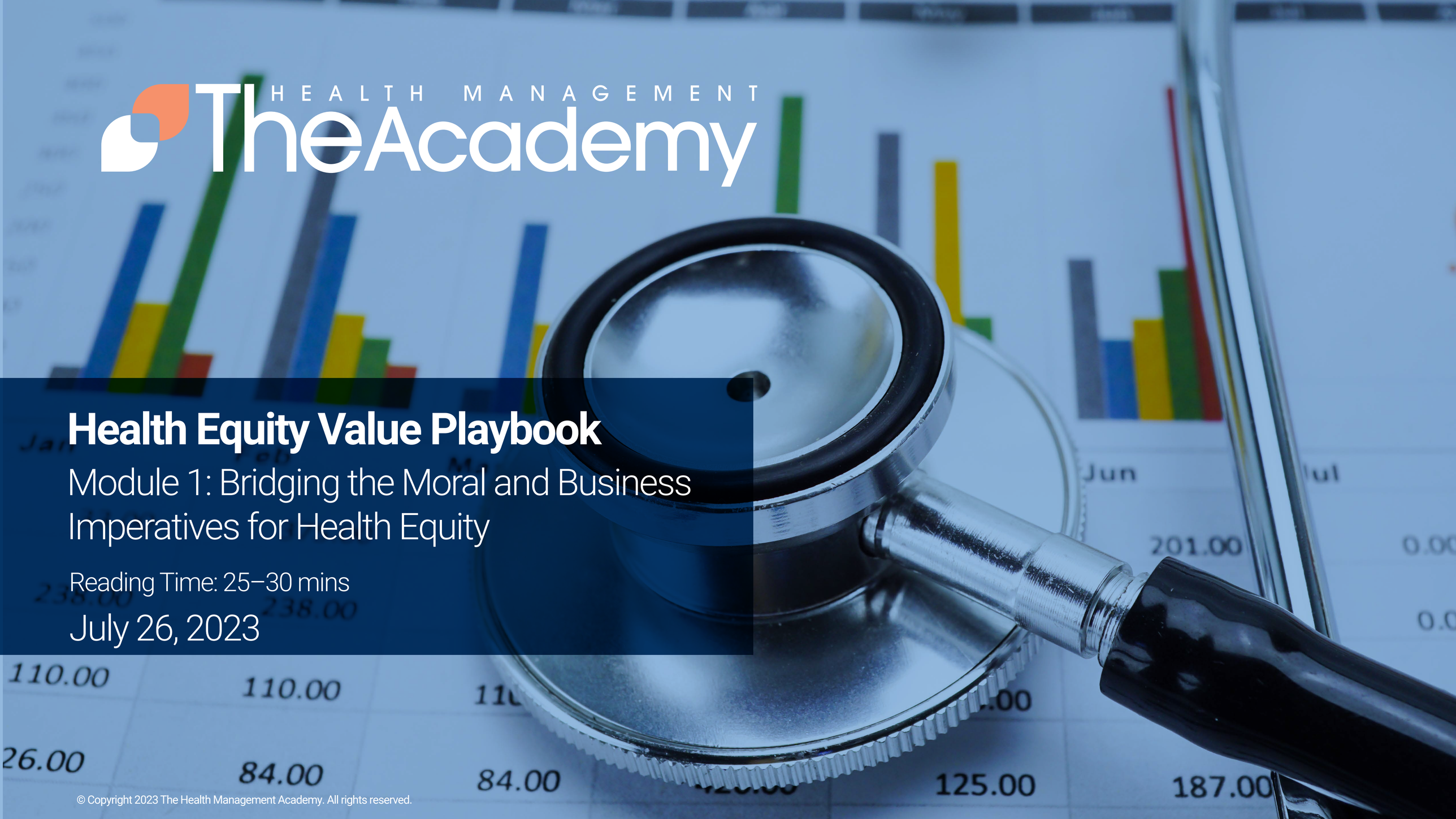


THE HEALTH MANAGEMENT Academy

# Health Equity Value Playbook

## Module 1: Bridging the Moral and Business Imperatives for Health Equity

Reading Time: 25–30 mins

July 26, 2023

# Health Equity Value Playbook Overview

Amidst financial headwinds and increased scrutiny of LHS operating budgets, health equity leaders are challenged to secure resources that support the organizational transformation effort that is required to achieve equity goals. This playbook presents practices and tools that support health system leaders in framing a business case for health equity across 4 different modules that will be released sequentially:

1

**Framing Health Equity as a Long-Term Driver of Value**

*(July 2023)*

## Module 1

This module provides guidance on bridging the moral and business imperatives of health equity using a new form of assessment—one that holistically looks at Total Value. The Total Value framework includes hard and soft ROI inputs, including sample metrics and timing considerations, and contextualized by critical influencers that impact performance of health equity investments.

2

**Money Talks: Unlocking the Language of Business and Finance**

*(January 2024)*

## Module 2

After framing the business case, the next step is to partner with your organization's finance leaders to identify feasible metrics. This module provides approaches to demonstrate linkages with health equity investments to larger system-wide business goals and includes a pro forma template to demonstrate the programmatic value of health equity.

3

**Determining Value: Moving from Program to Strategy**

*(Q1 2024)*

## Module 3

This module outlines components of a measurable health equity strategic plan and highlights case studies from health systems on approaches to measuring value at 4 different levels: system-wide, market, service line, and by initiative.

4

**Assessing Financial Sustainability and Next Steps**

*(Q2 2024)*

## Module 4

Being able to measure the long-term performance of health equity investments is critical to securing sustainable funding. Insights from this module cover key indicators to determine the long-term sustainability of a health equity initiative, including considerations on when to sunset vs. scale an initiative.

# Bridging the Gap: Health Equity as a Moral and Business Imperative

## LHS Embrace Environmental, Social, Governance (ESG) Responsibility

Since the COVID-19 pandemic, pressure from consumers, organizations, and government agencies have spurred health systems—and other industries—to prioritize socially responsive principles and values.[1] Leading health systems (LHS) are inherently mission-driven and many have begun embedding principles of environmental, social, governance (ESG) frameworks to support organizational and financial sustainability.


Health systems are continuing to embrace their social responsibility to address social drivers of health to deliver equitable care.[2] Executives and providers recognize decisions around health equity investments can not only drive their community benefit work, but greatly impact community well-being and health system performance.

> **"Health equity starts at the top with our governance. We have a diverse board, which we're proud of and our CEO is strong proponent of health equity. Health equity is everyone's job and doesn't rest on one person. It's not just an office, it permeates everything we do.**
>
> **– Chief Financial Officer, Leading Health System**

## Health Equity Supports Road to Long-Term Economic Savings

Many health system leaders agree that investing in health equity is not only the "right thing to do" but also a smart strategic business decision. Health inequities cost the industry nearly $320 billion and, if left unaddressed, could skyrocket to $1 trillion in annual spending by 2040. Increased spending would disproportionately impact historically underserved populations and widen existing disparities.[3]

**$451B** **Cost of racial and ethnic health disparities to the U.S. economy in 2018** [4]

In turn, health equity investments can address long-standing disparities and support cost mitigation. One estimate suggests eliminating health disparities would support significant economic gains of $135 billion—$93 billion in excess care costs and $42 billion in untapped productivity.[5]

And while the renewed focus on ESG has revealed new paths to generating value, health equity leaders must clearly articulate the financial and non-financial value of health equity to secure adequate resources.

> **"We're connecting our ESG work to our community benefit portfolio. The team and I deliberately focused our ESG work on 1) sustainability—reducing our carbon footprint which in turn, reduces costs, and 2) environmental justice. I think about how this work can greatly impact the health and welfare of vulnerable populations.**
>
> **– Chief Financial Officer, Leading Health System**

*Sources:*

1. Modern Healthcare. "ESG: Healthcare's new imperative. (link); 2. Lown Institute. "The "S" in ESG: How hospitals are embracing social responsibility." 2022. (link); 3. Deloitte. "US health care can't afford health inequities." 2022. (link)
4; Laveist, T., Perez-Stable, E., Richard, P. "The economic burden of racial, ethnic, and educational health inequities in the U,S," (link); 5. Altarum." The Business Case For Racial Equity: A Strategy For Growth." 2018. (link).

# Rise of Consumerism and Social Justice Enhances Opportunity Costs

The opportunity costs of not investing in health equity can have a long-lasting impact on health systems' bottom-line. Like healthcare, consumers in industries like retail or banking are increasingly making decisions based on an organization's perceived level of social responsibility. This is especially true among younger generations—in 2021, 70% of consumers ages 18 to 34 said that they would view a health system more positively if they demonstrated steps to address SDOH.[1] With the rise of consumers reporting adverse health system experiences via social media, health systems who fail to live up to their mission have the potential to lose brand loyalty and experience financial losses.[2]

## Opportunity Cost of Neglecting Health Equity [3]

### Brand Reputation

- Negative health system reputation due to lack of community stewardship
- Lack of community engagement lowers heath system trustworthiness

- Invites ongoing negative publicity
- Exacerbates labor challenges due to negative employer perception
- Subsequent loss of patient loyalty
- Subsequent loss of social impact projects (i.e., with community leaders, local government, businesses)

### Financial Losses

- Higher healthcare expenditures due to ineffective and inefficient care delivery
- Widened disparities and poorer health outcomes
- Viral patient experiences of inequitable care

- Incurs patient litigation costs
- Subsequent loss of contracting opportunities, particularly state government or philanthropic stakeholders

### Case Example: Community Benefit

Over the past couple of years, health systems' non-profit status has become increasingly scrutinized by federal and state lawmakers. Many of these complaints highlight that non-profit health systems' do not "earn" their tax breaks because they fail to meet their community benefit obligations:

- An OH-based health system underwent a federal civil rights investigation after the closure of a Dayton safety net hospital. The complaint alleged that this closure indicated a divestment from the underserved Black community in the city.[4]
- The closure of an Atlanta safety net hospital led to 2 federal complaints being filed against the GA-based health system, citing the hospital's CHNA which had identified access as a priority issue.[5]

**"Our opportunity cost is two-fold—with a [highly publicized] situation, you can get into big litigation, bad press in media, negative publicity and press that will come back to haunt you financially no matter what…It pays off in big dividends if they see how much you care and be a good community partner."**

**– Chief Financial Officer, Leading Health System**

SDOH: Social Determinants of Health; CHNA: Community Health Needs Assessment

*Sources:*

1. Bloomberg. "Corporations face a reckoning on race." (link); 2. Forbes. "How one woman's story of medical neglect highlights the pervasive issue of racism in healthcare." (link); 3. Academy research and analysis;
4. Parker Perry. "Federal investigation finds no civil rights violations in Good Sam Hospital closure." (link); ; 5. Jeff Amy. "Atlanta hospital closure inquiry sought by Georgia Democrats." (link).

# Health Equity "Total Value" Seen but Remains Undefined

## Traditional Return-on-Investment Only Tells Part of the Story

Most health system executives have a set of criteria to evaluate the return on investment (ROI) of systemwide initiatives. Typically finance leaders are looking for an immediate positive return within one year but in reality, the ROI of health equity can take at least three to five years—if not more—to mature. **There are two main reasons why the standard ROI framework does not capture the impact of health equity:**

1

### Standard ROI ignores "soft" and "strategic" ROI of health equity initiatives.

As it's measured today, ROI focuses on financial outputs and fails to account for "soft" and "strategic" ROI which are typically qualitative and long-term in nature. Solely focusing on hard ROI misses the mark on capturing the full benefits of health equity investments.

2

### Positive ROI takes time to kick in.

Understandably, health systems rely on predictable revenue to allocate resources. Yet many health equity initiatives take time to reach critical mass. For example, Strong Beginnings, a multistakeholder collaborative to drive well-being for families of color saw a 32% decrease in infant mortality among African Americans in Kent County over a 10-year period.[1,2] Health systems must stay the course to reap health equity investment benefits which can be difficult during a financial downturn.

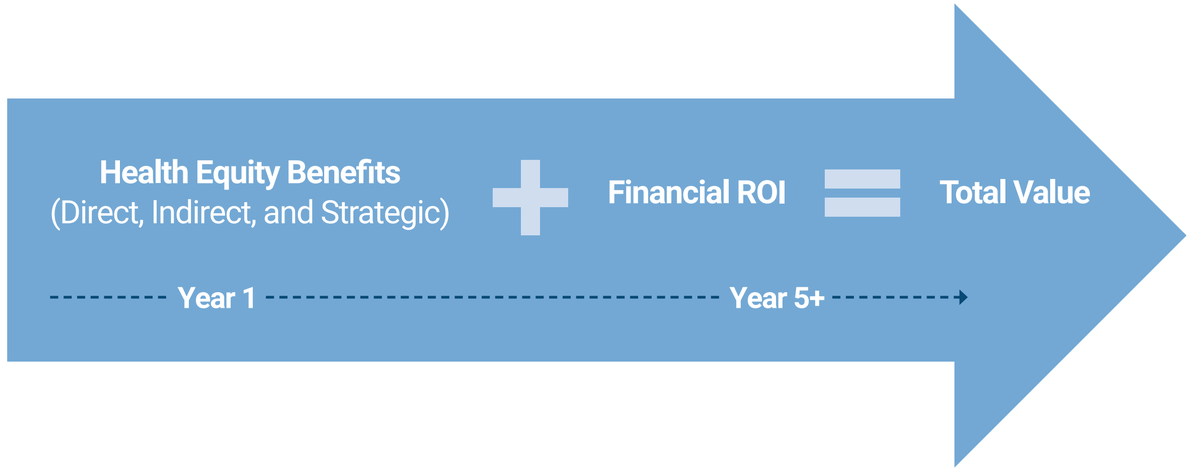
Health system executives agree that there is a need for a holistic assessment of health equity investments. **This holistic measure is the "total value."**

## Introducing the "Health Equity Total Value" Framework

To help health system leaders comprehensively assess health equity investments, The Health Management Academy adapted a "total value" framework.1 This framework is based on our qualitative, in-depth interviews with leading health system executives and a comprehensive literature review.

**The goal is to replace the standard ROI calculation with total value to ensure health systems consider:**

- Both the financial and non-financial benefits of health equity investments using a comprehensive set of measures over extended periods of time;
- The impact on urgent needs and shifting market trends, such as workforce shortages; and
- If health equity investments should be scaled to other parts of the health system.




*Sources:*

1. Academy Research and Analysis [2] The Terry Group. "The Business Case for Investing in Health Equity." (link).

# Roadmap to Measure Health Equity's Total Value

## An Overview of the Health Equity Total Value Framework

The health equity total value framework is made up of four important categories (see below and Figure 1).

- **Direct benefits** assess the impact of health equity investments on healthcare revenue and expenditures.1 The four inputs are loss avoidance, quality gains, clinical revenue gains, and operational efficiencies.
- **Indirect benefits** or "soft" ROI are often qualitative in nature and harder to measure, yet they involve positive feedback loops that can support financial ROI.[1] The four inputs are brand reputation (internal), brand reputation (external), partnership opportunities, and community benefit investments.
- **Strategic benefits** account for the business and societal advantages for investing in health equity. Inputs include shift to value-based care, market capture and growth, and retaining long-term patient loyalty.
- **Financial ROI** or "hard ROI" refers to the financial profitability of health equity interventions. The inputs are overall revenue capture (which includes accelerated cash flow) and cost reduction. Direct, indirect, and strategic benefits will all impact or influence these two inputs.

These categories are explored in greater detail on pages 9-14, including sample sources of value for each input.

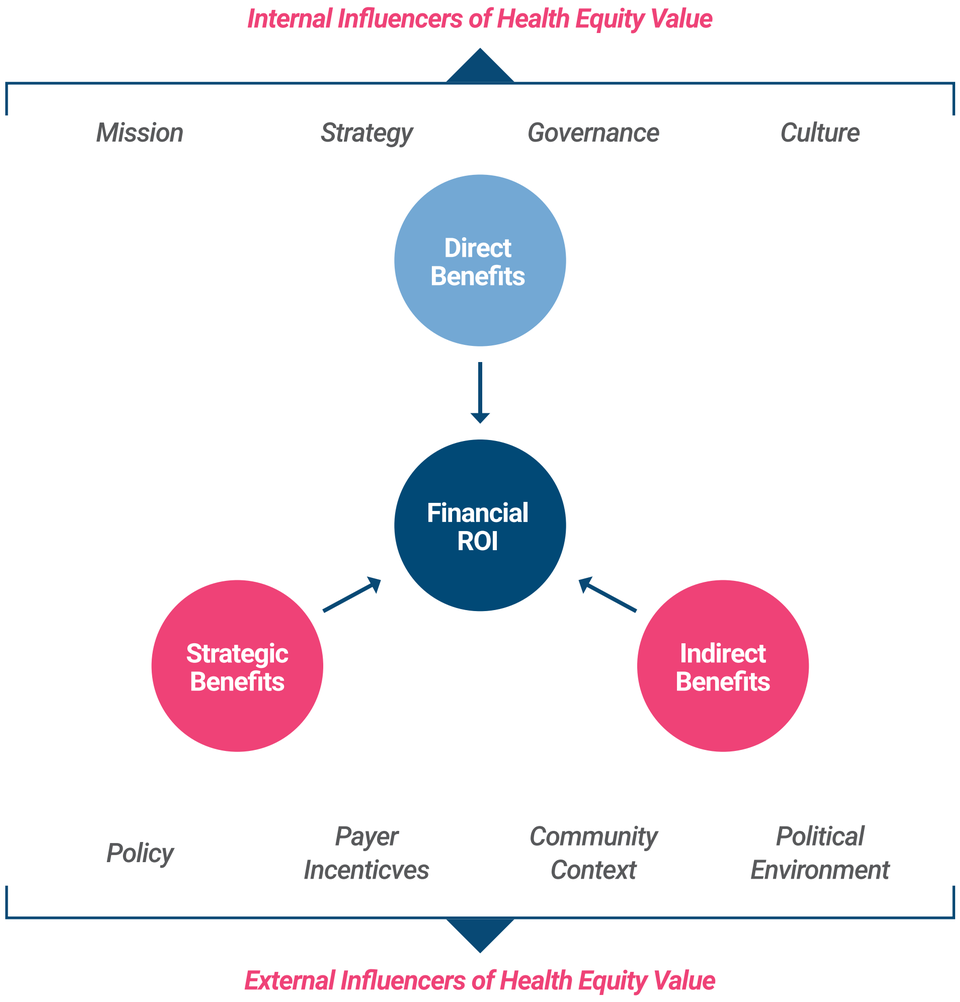
### Critical Influencers

The last part of the total value framework is critical influencers. Critical influencers are not metrics. Rather, they are inputs which impact a health system's ability to demonstrate the value and scale of health equity investments. The internal and external influencers are discussed in more detail on page 7.

### Considerations for Measuring Value Across Years 1-5

It takes longer to see the impact of some benefits. The goal is to have an of understanding total value across five years (or more). Note that "Year 1" begins once a health equity intervention has been fully implemented. Initially, "soft" ROI will justify the financial investment. But over time, health equity benefits (direct, indirect, strategic) will drive clinical outcomes and support the financial case. As such, organizations need to take these performance lags into consideration.

**Figure 1. Total Value Framework for Measuring the Impact of Health Equity**




*Sources:*

1. The Terry Group. "The Business Case for Investing in Health Equity." (link).

# “Influencers” Critical to Achieve Health Equity Value

In building the total value framework, it was clear that total value inputs do not operate in a silo—additional factors influence the financial ROI and benefits of health equity investments. While there are many factors that can impact total value over time, our research found eight impactful internal and external health system influencers.

## Internal Influencers of Health Equity Value

**Mission.** Health systems are inherently mission driven, focused on providing high-quality, accessible care. Investing in health equity supports a health system’s social responsibility to address the social drivers of health to create healthier communities.

**Strategy.** More than ever, health equity is a top strategic priority—78% of LHS have a system-wide health equity strategy.[1] Health systems that prioritize health equity investments are more likely to reap powerful downstream effects: 1) fulfill their community benefit and tax-exemption requirements; 2) increase access to care; 3) build patient loyalty and trust; and 4) long-term cost savings by addressing longstanding health disparities.

**Governance.** A health system’s board and leadership is critical to resource allocation and defining systemwide health equity goals. Leadership support and commitment to health equity drives progress allowing investments to mature to produce long-term financial ROI.

**Culture.** A newfound sentiment among financial leaders is health equity is now “everyone’s job.” Creating a workforce culture which embraces the goal to dismantle structural racism and barriers to support community well-being is tied to the direct, indirect, and strategic benefits of health equity investments.

## External Influencers of Health Equity Value

**Policy.** State and federal agencies are advancing health equity measurement and identifying accountability mechanisms to incentivize health equity investments.

**Payer Incentives.** Outcomes-focused payment models incentivize health systems to invest in health equity. While value-based contracts may require upfront costs, they can support long-term care delivery transformation.

**Community Context.** Each community has unique challenges and strengths that influence a health system’s role in effective change. Using data to assess community inequities and understanding its historical context—including a health system’s role in perpetuating inequities—is a critical factor in determining community support and participation in community investments.

**Political Environment.** The political landscape ultimately impacts resource allocation and a health system’s ability to invest in health equity initiatives.

*Sources:*

1. The Health Management Academy. 2021 Governance & Executive Leadership Trends Across Leading Health Systems. 2021

# How Direct Benefits Support Financial ROI

To provide further clarity on potential sources of value that drive direct and proxy contributions to financial ROI, each component of the total value framework is broken down into measurable inputs. Direct benefits are quantifiable outcomes that can be realized in the short-, mid-, and long-term and are typically included in standard ROI analyses. Direct benefits consist of four inputs:

1

## Loss Avoidance

The financial burden of health inequities represent avoidable losses for health systems. By addressing upstream factors like SDOH and identifying high-cost patient segments, health equity investments can address healthcare overutilization and increase access, ultimately reducing the total cost of care.[1]

2

## Quality Gains

Applying an equity lens to disparities-sensitive quality measures can identify overlooked disparities (e.g., through stratification by race and ethnicity), which can inform optimal resource allocation in quality projects and reduce costs. [1]

3

## Clinical Revenue Gains

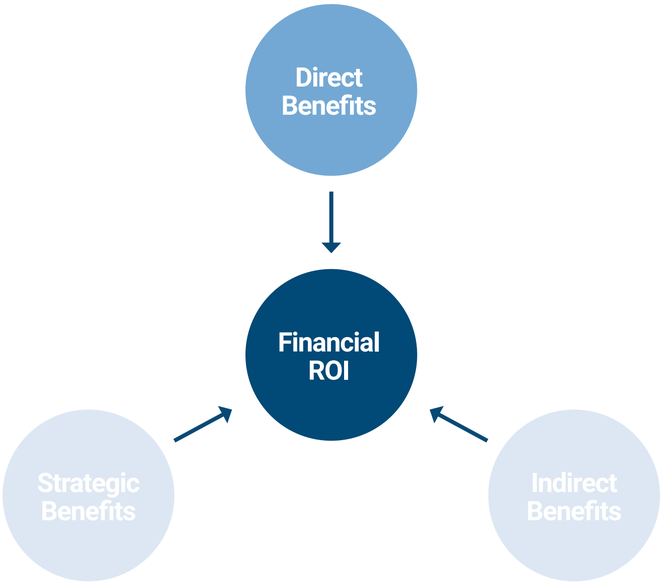
Quality gains can bring in additional revenue as they are often tied to value-based payment incentives. Health equity initiatives can also unlock new billing opportunities for the system.[1,2]

4

## Improved Operational Efficiencies

Integrating an equity lens into care delivery can optimize allocative and technical efficiencies through appropriate resource distribution ("doing the right thing, at the right place") while minimizing costs for desired outcomes ("doing more with less").[3,4]

**Total Value Framework: Direct Benefits**




*Sources:*

1. Academy research and analysis; 2. The Commonwealth Fund. Capturing value in social health: Lessons in developing the business case for social health integration in primary care. (link); 3. OECD. "Developing indicators of health care efficiency." (link); 4. Health Affairs. "The high costs of ignoring health inequities." (link); 5. The Terry Group. "The Business Case for Investing in Health Equity." (link).

# A Closer Look at Sources of Value – Direct Benefits

**Overview:** Direct benefits are comprised of metrics that demonstrate the financial impact of health equity investments on healthcare revenue and expenditures:

1. **Loss avoidance:** Loss avoidance is best measured by assessing reductions in variable direct costs of care. Metrics should demonstrate that the health equity investment will mitigate inappropriate healthcare utilization (e.g., shifts from high-cost to low-cost settings) and/or improve appropriate healthcare utilization (e.g., increase in primary care visits).
2. **Quality gains:** Look for common quality metrics across your health system's incentive-based contracts, starting with process measures in year one and advancing to intermediate and secondary outcome measures in the mid-term.
3. **Clinical revenue gains:** Consider where there are opportunities to integrate health equity into revenue optimization strategies. Metrics should demonstrate revenue gains from novel reimbursement opportunities and subsequent reduction in uncompensated care.
4. **Improved operational efficiencies:** Detailed cost analyses can demonstrate efficiency gains by redistributing resources (e.g., shifting care navigation responsibilities from a nurse to community health workers in a care team) and/or implementation of a low-cost solution (e.g., a text-based intervention for underserved populations).

| | **Domain 1**<br>Loss Avoidance<br>*(Stratified metrics)* | **Domain 2**<br>Clinical Quality Gains<br>*(Stratified metrics)* | **Domain 3**<br>Clinical Revenue Gains | **Domain 4**<br>Operational Efficiencies |
|---|---|---|---|---|
| Short-Term (Year 1) | ❒ ED utilization<br>❒ Length of stay<br>❒ 30-day all-cause readmission rate<br>❒ Referral rates to ambulatory specialty care | ❒ Colorectal cancer screening<br>❒ Breast cancer screening<br>❒ Screening for high blood pressure with documented follow-up | ❒ Private payer reimbursement for use of Z codes | ❒ Time savings by redistribution of work across a care team<br>❒ Time savings through use of social needs referral platforms |
| Mid-Term (Years 2-4) | ❒ Primary care utilization<br>❒ Condition-specific 30-day readmission rate (e.g., heart failure)<br>❒ Avoidable ED utilization | ❒ Hospital-acquired infections (e.g., sepsis)<br>❒ Hemoglobin A1c control for adult patients with diabetes (>9%)<br>❒ Blood pressure control for adult patients with hypertension | ❒ Medicare reimbursement for chronic care management services<br>❒ Medicaid reimbursement for community-based health workers (e.g., doulas, CHWs)<br>❒ Reduction in uncompensated care | ❒ Cost savings through warranted variation in care delivery<br>❒ Cost savings by shifting non-clinical responsibilities to community-based health workers (e.g., doulas, CHWs) |
| Long-Term (Year 5+) | ❒ Total cost of care | ❒ Shared savings opportunities from meeting quality benchmarks in VBAs<br>❒ Enhanced payer rates from incentive-based contracts by demonstrating quality gains | ❒ Reimbursement gains from participation in new bundled payment programs or VBAs<br>❒ Enhanced payer contract rates due to consistent total cost of care reductions | ❒ Long-term cost savings by scaling intervention across the health system |

For more information, review "The High Cost of Ignoring Health Equities" (May 2023)

*Note: Year 1 refers to the first year after implementation.*

*Please note that the metrics and indicators included in this report are intended to be examples only and do not represent an exhaustive list of supportive sources of value for health equity.*

*ED: Emergency Department; CHW: Community Health Worker; VBA: Value-Based Agreement*

*Sources:*

1. Terry Strategies. "The business case for investing in health equity." (link); 2. Academy research and analysis; 3. The Commonwealth Fund. Capturing value in social health: Lessons in developing the business case for social health integration in primary care. (link)

# Indirect Benefits Are Proxy Indicators for Stakeholder Value Driving ROI

Indirect benefits are an important piece of the puzzle and represent mid- to long-term gains. While they are not directly tied to financial ROI, indirect benefits can be used as a proxy to .assess the health system's value to internal and external stakeholders. These perceptions of value ultimately influence decision-making related to engaging with your health system and has an indirect impact on overall revenue capture and ability to reduce costs.

1

## Brand Reputation (Internal)

Involvement in social impact initiatives can increase employee engagement and retention rates, creating a comparative advantage for health systems as employers in the labor market.[5]

2

## Brand Reputation (External)

Addressing inequities and unmet needs build trust, especially among underserved communities, potentially leading to better patient retention and increased patient growth from non-engaged populations.[5]

3

## Partnership Opportunities

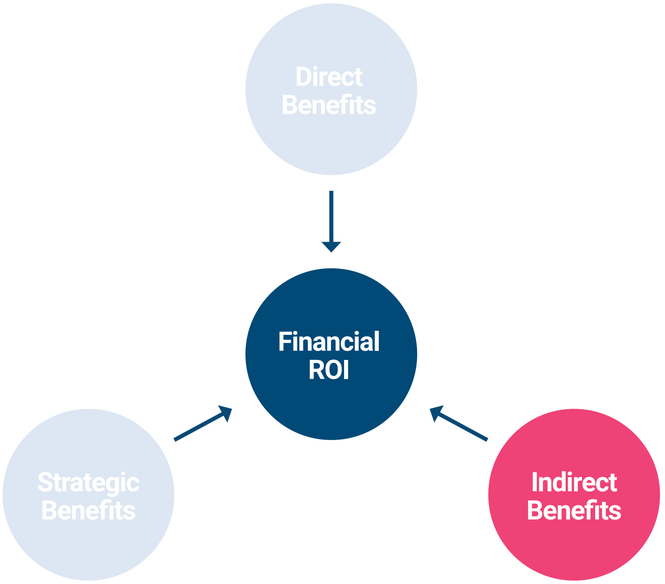
Community-based partnerships can increase health system capacity to address SDOH among underserved populations and enhance financial returns of health equity initiatives. Health system stewardship can facilitate business partnerships and grants from government agencies and private foundations.

4

## Community Benefit

Investing in community health and well-being can stimulate local economies and create positive feedback loops that not only benefit other sectors (e.g., education, local businesses) but the health system itself (e.g., trustworthiness).

**Total Value Framework: Direct Benefits**




*Sources:*

1. Academy research and analysis; 2. The Commonwealth Fund. Capturing value in social health: Lessons in developing the business case for social health integration in primary care. (link); 3. OECD. "Developing indicators of health care efficiency." (link); 4. Health Affairs. "The high costs of ignoring health inequities." (link); 5. The Terry Group. "The Business Case for Investing in Health Equity." (link).

# A Closer Look at Sources of Value – Indirect Benefits

**Overview:** Indirect benefits consist of proxy metrics or sources of value that capture value delivered to stakeholders beyond the health system itself. They consist of 4 inputs:

1. **Internal brand reputation:** Employer reputation can be measured by how well a health system attracts and retains a diverse workforce. To measure early impact, look first at engagement or employee satisfaction scores. Over time, health equity investments can lead to fewer staff vacancies and lower turnover.
2. **External brand reputation:** Health system reputation in the community can be measured by both patient experience and engagement. Systems should start with existing consumer measures (or other loyalty metrics). In the long-term, these metrics can be supplemented with qualitative data that demonstrate health system brand appeal and opportunities to grow a health system's "share of care" in respective markets.
3. **Partnership opportunities:** Health systems can evaluate the value of community partnerships through the number of net new patients from community partners. This domain could also be measured via new funding sources or business opportunities due to partnerships that would be otherwise inaccessible to health systems.
4. **Community benefit:** Improving patient access and affordability can address direct cost burdens on communities. Health systems should pay attention to their community benefit spending (i.e., IRS Form 990) as these costs are increasingly scrutinized in health systems rankings and inform media narratives that influence patients' healthcare choices.

| | **Domain 1**<br>Internal Brand Reputation<br>*(Stratified metrics)* | **Domain 2**<br>External Brand Reputation<br>*(Stratified metrics)* | **Domain 3**<br>Partnership Opportunities | **Domain 4**<br>Community Benefit |
|---|---|---|---|---|
| Short-Term (Year 1) | ❒ Employee engagement (e.g., Glint survey) | N/A | ❒ Formal partnerships (e.g., community-based organizations, foundations)<br>❒ Percent spend on minority and women-owned business enterprises (MWBE) suppliers | ❒ Ratio of charity to compensated care |
| Mid-Term (Years 2-4) | ❒ Employee job satisfaction<br>❒ Employee retention rates<br>❒ Employee absenteeism rates<br>❒ Vacancy rate<br>❒ Turnover rate | ❒ Patient satisfaction (e.g., NPS)<br>❒ Patient access measures (e.g., number of days to schedule a PCP appointment)<br>❒ Composite patient experience scores (e.g., HCAHPS)<br>❒ Patient word-of-mouth referrals<br>❒ Growth in unique individuals engaged with the system | ❒ Generated revenue from community partners<br>❒ New funding sources through formal community partnerships<br>❒ New contracting opportunities from maintaining adequate proportion of spend on MWBE suppliers | ❒ Patient affordability (e.g., out-of-pocket costs)<br>❒ Health system ranking by ratings organizations (e.g., US News & World Report, Lown Institute) |
| Long-Term (Year 5+) | ❒ Employee retention rates<br>❒ Employee engagement<br>❒ Vacancy rate<br>❒ Turnover rate | ❒ Composite patient experience scores<br>❒ Patient retention<br>❒ Patient satisfaction<br>❒ Health system perception among underserved communities | ❒ Additional generated revenue from community partner referrals<br>❒ Renewed contracting opportunities that have an MWBE requirement<br>❒ Renewed philanthropic contributions and grant funding<br>❒ Renewed formal community partnerships | ❒ Sentiment analysis of health system reputation in media and social media narratives<br>❒ Dollar benefit of community investments for other local sectors (e.g., education, housing, criminal justice) |

*Note: Year 1 refers to the first year after implementation.*

*Please note that the metrics and indicators included in this report are intended to be examples only and do not represent an exhaustive list of supportive source of value for health equity.*

*Sources:*
1. Academy research and analysis; 2. Gupta et al. "The affordability accelerator: A road map to improve patient out-of-pocket costs and trustworthiness in health care"

# Long-Term Strategic Benefits Prime LHS for Future ROI Capture

Strategic benefits capture whether a health system is positioned for long-term success given broader market and demographic trends. While they are also not directly tied to financial ROI, strategic benefits can be used to assess how health equity investments lead to sustainable improvements in preparing a "future-proof" health system.

1

## Shift to Value-Based Care

Health systems are subject to payer incentives that prioritize equitable outcomes and lower total cost of care. In a value-based world, those who are proficient in identifying high-risk patient segments are more likely to optimize resources and deliver efficient, patient-centered care, becoming well positioned to take on downside risk and achieve savings.

2

## Market Capture and Growth

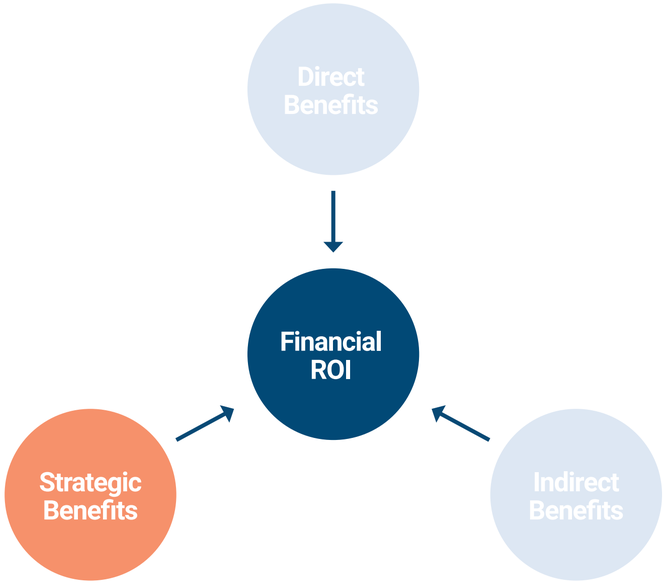
Over time, sustained investments and engagement with underserved communities can differentiate your health system as a trusted partner. As health systems prioritize the patient voice in decision-making, a positive reputation can set your health system apart and have long-term payoff. [2]

3

## Retaining Long-Term Patient Loyalty

The Census Bureau projects that the US will become a "majority-minority" country by 2045.[3] To grow or even maintain a consistent market share, health systems that can take an intersectional approach to care delivery will be better positioned to serve an emerging diverse population.

**Total Value Framework: Direct Benefits**




*Sources:*

1. Academy research and analysis; 2. Forbes. "Is the era of healthcare consumerism finaly here? New survey says yes." (link); 3. Brooking Institute. "The US will become 'minority white' in 2045, Census projects." (link)

# A Closer Look at Sources of Value – Strategic Benefits

**Overview:** Strategic benefits are also hard to measure but represent value drivers that drive long-term success. It consists of 3 inputs:

1. **Shift to value-based care:** The generated return from health equity investments is higher under value-based arrangements than fee-for-service payments. As the adoption of downside risk increases, demonstrating how a focus on equity could lead to your system's future success in VBC (e.g., increasing effectiveness and efficiency of high-risk care management). This domain may not be applicable to every health system and is dependent on the level of VBC adoption.
2. **Market capture and growth:** The value of health equity investments can support patient loyalty and can be measured using patient leakage metrics. The level of health system trust is also crucial to market capture and can be measured by deploying community-engaged research methods to collect qualitative data on community trust.
3. **Retaining long-term patient loyalty:** Ensuring your health system's success in an increasingly diverse America requires a comprehensive understanding of your patient demographics. Patient/workforce racial and ethnic concordance is a key facilitator to improving health outcomes and culturally sensitive care delivery. In the long-term, demonstrating the opportunity cost of failing to address existing disparities—particularly among high-growth demographic groups in your community—will be critical as these costs will only rise as they constitute a larger proportion of the population.

| | **Domain 1**<br>Shift to Value-Based Care | **Domain 2**<br>Market Capture and Growth | **Domain 3**<br>Retaining Long-Term Patient Loyalty |
|---|---|---|---|
| Short-Term (Year 1) | N/A | N/A | N/A |
| Mid-Term (Years 2-4) | ❒ Percentage of patient revenue tied to VBC contracts<br>❒ Impact of health equity investments on quality metrics included in VBA (e.g., decrease in ED use) as an indicator of potential future success under VBC | ❒ Retention of health system "share of care" via improved keepage of patients from underserved communities across the care continuum<br>❒ Community residents who accessed elective care at the hospital | ❒ Rate of provider racial, ethnic, or linguistic concordance with patients, including medical residents<br>❒ Rate of non-clinical staff racial, ethnic, or linguistic concordance with patients<br>❒ Rate of patient racial, ethnic, or linguistic concordance with community in which hospital is located |
| Long-Term (Year 5+) | ❒ Financial gains from consistent attribution of high-risk patient panels under different value-based arrangements<br>❒ Comparative financial gains under FFS vs. VBC payment arrangement | ❒ Gains in health system "share of care" via reduced patient leakage across the care continuum<br>❒ Qualitative measures of community trust via anchoring efforts (e.g., community events) or patient engagement efforts (e.g., CHNA)<br>❒ Growth in unique individuals from underserved communities engaged with the health system | ❒ Avoidable direct costs tied to health disparities among patients from high-growth demographic groups in high-need ZIP codes served by the health system, based on U.S. Census Bureau projections |

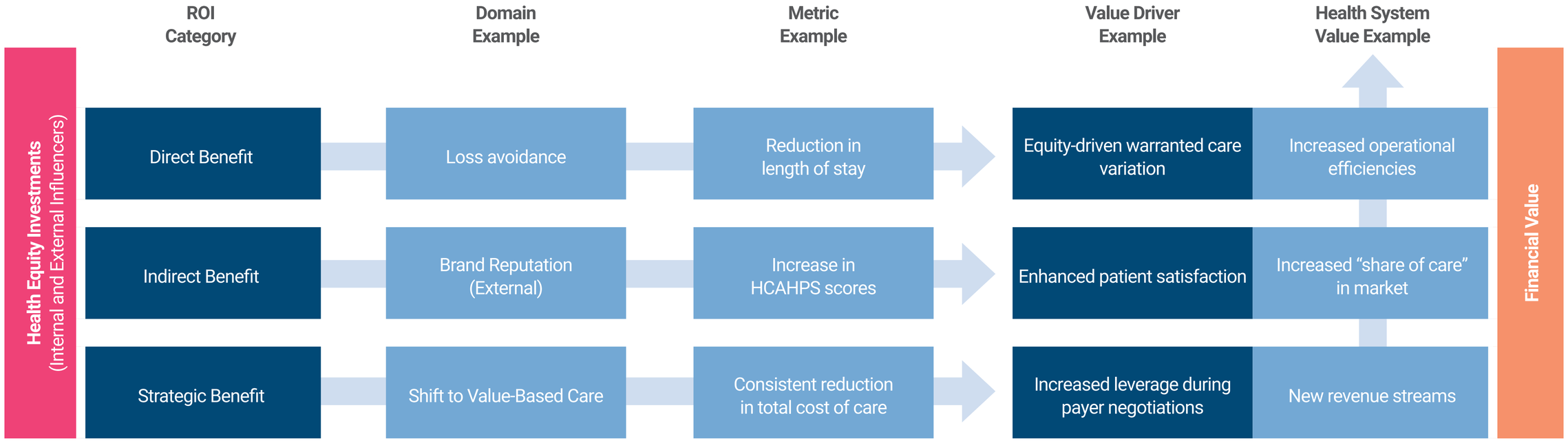
*Note: Year 1 refers to the first year after implementation.*

*Please note that the metrics and indicators included in this report are intended to be examples only and do not represent an exhaustive list of supportive source of value for health equity.*

*Sources:*
1. Academy research and analysis; 2. Forbes. "Is the era of healthcare consumerism finally here? New survey says yes." (link); 3. Brookings Institute. "The US will become 'minority white' in 2045, Census projects." (link)

# Metrics Should Balance Short-Term and Long-Term Value Proposition

In collaboration with finance, health equity leaders must demonstrate the financial sustainability of health equity investments. The goal is to move away from short-term funding (e.g., grants, philanthropy) towards sustainable funding sources (e.g., health system operating budget). This requires aggregating the valuation of health equity by health system, patient, payers, and community perspectives.[1] To do this, the business case should demonstrate a range of outcomes over time using metrics "that capture relevant sources of value representing direct, indirect, and strategic benefits, ideally over 3-5 years.[2]




"You don't have near-term returns. State how you're going to monitor and report it in the meantime...My preference is the portfolio approach. **There's a honeymoon period I know we're not going to see direct returns**, but I want to see how we're doing and evaluating [the investment]."

– Chief Financial Officer, Leading Health System

*Sources:*
1. HealthLeads. "The collaborative to advance social health integration." (link); 2.Terry Strategies. "The business case for investing in health equity." (link); 3. EY. "How to position health equity as a long-term value driver." (link); 4.Academy research and analysis.

# Value Should Be Tied to Level of Value-Based Payment Adoption

Proxy metrics will vary and are dependent on factors including payer mix, health system strategy, community, and targeted disparities. Importantly, business case analyses should consider a health system's level of value-based payment (VBP) adoption to identify applicable total value metrics.[1] For example, health systems operating in a predominantly fee-for-service (FFS) environment can demonstrate the contribution margin of inadequate payer reimbursement for a particular Diagnosis-Related Group (DRG) and potential revenue losses by case mix (e.g., resource intensity, patient characteristics) when an equity lens is not applied. In contrast, organizations that have a robust value-based enterprise like an accountable care organization (ACO) can utilize claims data to demonstrate cost savings across metrics in their value-based contracts.

## Examples of Value Sources Across Health System Business Models [1]

### Fee-for-Service (FFS)

**Variable Direct Costs of Care**

- Reductions in avoidable ED use
- Reductions in uncompensated care
- Contribution margin of payer reimbursement for DRG bundles

**Patient Satisfaction**

- Increase in HCAHPS scores in ambulatory settings

### FFS, but moving towards value-based contracts

**Variable Direct Costs of Care**

- Reductions in avoidable ED use
- Reductions in uncompensated care
- Increased use of lower-cost settings compared to higher-cost settings

**New Billing Opportunities**

- Added reimbursement for chronic care management services

### Performance Incentives

**Variable Direct Costs of Care**

- Reductions in avoidable ED use
- Increased primary care utilization
- Reductions in length of stay
- Reductions in total cost of care

**Patient Outcomes** (Stratified)

- Improvement in diabetes A1C levels >9%

### Risk-Based Payment

**Variable Direct Costs of Care**

- Reductions in total cost of care in ACO settings
- Reductions in total cost of care

**Patient Outcomes (Stratified)**

- Improvement in diabetes A1C levels >9%
- Increased rates of colorectal cancer screening

Paid for volume of services

**Business Model**

Paid for health outcomes

ED: Emergency Department; HCAHPS: Healthcare Consumer Assessment of Healthcare Providers and Systems

*Sources:*

1. The Commonwealth Fund. Capturing value in social health: Lessons in developing the business case for social health integration in primary care. (link); 2. AAFP. How to succeed in value-based care. (link).

# Research Methodology

From November 2022 – February 2023, the Health Equity Alliance (HEA) research team conducted 11 in-depth qualitative interviews with Leading Health System (LHS) finance executives and health equity leaders regarding their perspectives on determining health equity value and identifying strategies to build a business case for health equity investments. The interview data was used to validate and supplement relevant findings from secondary research identified through a literature review, including adapting Terry Strategies' "Expanded ROI Framework" to the LHS context.

## THMA Project Team

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## Looking Ahead

This framework is intended to be a living resource that will be regularly updated based on member feedback and industry trends. Do you have suggestions on how we can improve the utility of upcoming playbook modules for (HEA) members? Are there any tools or resources that would be most helpful in addressing key pain points related to building the case for health equity?

Please send your suggestions to healthequityalliance@hmacademy.com!

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