



The Importance of Community Partnerships Case Examples 2



American Hospital
Association



community
CONNECTIONS



**American Hospital
Association**

Photos in the publication are courtesy of Doug Haight, photographer, and illustrate programs from recent Foster G. McGaw Prize-winning organizations.

TABLE OF CONTENTS

Community Connections Overview	1
Community Partnerships Overview	2
Partnering with Public Health	3
Executive Summary	4
Case Examples	7
Summary/Conclusions	17
Index	18

COMMUNITY CONNECTIONS OVERVIEW

America's hospitals are about people taking care of people, often at the most vulnerable times in their lives—a responsibility that hospitals take very seriously. The work hospitals engage in goes further than treating injury and illness. Hospitals also endeavor to make the people in their communities healthier. Every day in America, hospitals are hard at work, helping improve health, wellness and access to care in the communities they serve. A hospital's impact and service extend far beyond the walls of a brick building, bringing free clinics, job training, smoking cessation classes, back-to-school immunizations, literacy programs and so many other resources—often with little fanfare—directly to the people of the community.

Across the country, health care needs are growing and changing. Among other factors, the baby boomer generation is aging, and the obesity epidemic and the number of Americans suffering from chronic illness are increasing. As hospitals address these growing health care needs and the changing landscape of health care delivery, the importance of prevention and wellness as well as the ability to provide well-coordinated care is paramount. Now, more than ever, it's important that hospitals effectively connect with their communities—with their patients, with their caregivers and with their neighbors.

Hospitals will not be able to meet all of the varied health care and social needs within their communities, but through connecting, working and partnering with other community organizations, wonderful results can occur. The strength and scope of a hospital's ability to care for its community are substantially leveraged and enhanced through collaborative projects and partnerships made up of hospitals and other organizations working together to meet the health needs and improve the health status of the community.

Community Connections is a long-term initiative of the American Hospital Association (AHA) aimed at helping hospitals across America reaffirm their important role as valued and vital community resources that merit broad public support. It is the hope of the AHA that

the concept of Community Connections will be an anchoring theme as hospitals formulate their own effective strategies for listening, communicating and collaborating with their communities.

Through the Community Connections initiative, hundreds of examples of hospitals engaging in community service and outreach activities have been captured. The activities and programs vary significantly, as do the needs of individual communities. The innovative programs, services and management strategies identified illustrate that hospitals across America are working to improve the health of their communities and are doing so in concert with other organizations within their communities.

Each year, a collection of these case examples has been printed in a booklet and mailed to every hospital in the country; they also are available on the Community Connections website, www.ahacommunityconnections.org. These examples provide new ideas, insights and perspectives that others can put to work as part of their own leadership plans. Additionally, a number of tools and resources have been developed to help hospitals build the needed organizational infrastructure to support an ongoing, multi-faceted effort to forge community ties and expand community engagement, which can inform and drive organizational performance.

COMMUNITY PARTNERSHIPS OVERVIEW

Several years ago, with the support and advice of hospital and other health care leaders from across the country, the American Hospital Association Board of Trustees developed a roadmap for improving America's health care system. This framework — *Health for Life: Better Health. Better Health Care.* — contains a set of goals and policies for creating better, safer, more efficient and affordable health care and a healthier America. The AHA used this framework through the health care legislation debate as a guidepost both to influence and evaluate key elements in the transformation of our health care delivery system.

Ultimately, the new law, the *Patient Protection and Affordable Care Act*, reflected many of the key principles in AHA's Health for Life framework, including advancing wellness and prevention efforts as well as improving efficient, affordable care through care coordination. The AHA will continue to provide support and assistance to hospitals to advance these principles and, thus, to advance a delivery system that improves health and health care for all.

The CEO Insight Series is intended to provide examples and lessons learned from hospitals and health systems that have successfully collaborated with their public health departments to promote health within their communities. Health care organizations from across the country were interviewed on collaborations that successfully leverage resources and efforts while addressing broader community health concerns. This kind of collaboration has the potential to more effectively achieve any number of goals, including: increasing access and coordination of care; reducing duplicative efforts and services; filling gaps in services; empowering patients to better manage their health; and promoting healthier lifestyles.

Interviews focused on the impetus for the programs, the mission and role of the hospital or health system in the partnerships, measuring and communicating the success of the collaborations, funding and sustainability and advice to others.

In addition to the case examples, the executive summary identifies common learnings and themes from these successful programs. This information is intended to help other hospitals and health systems as they look to form community partnerships to tackle community health issues. Each case example includes contact information for individuals who can provide more detailed information about their experiences. Additionally, more case examples can be accessed at www.ahacommunityconnections.org.

Forming community partnerships takes time and effort but as the examples in this publication illustrate, the positive return in better community relations and connections, as well as better health for the community, more than outweigh the effort. The AHA hopes that the lessons learned and these examples will provide ideas and inspiration for others as they seek to connect with local partners to improve the quality of life in their communities.



PARTNERING
WITH PUBLIC
HEALTH

PARTNERING WITH PUBLIC HEALTH

EXECUTIVE SUMMARY

Impetus for Programs

The case examples highlighted in this *Insight Series* represent a broad range of hospital efforts to reach out to the community and coordinate care across a variety of health care providers, including public health organizations. Some of the programs were developed to address a specific community health need or challenge, such as better coordination of care for asthma patients, tobacco cessation, substance abuse prevention, increasing immunization rates and enhancing access to care for adolescents and teenagers. Other partnerships were formed around the concept of conducting a community needs assessment to identify the greatest challenges. Several organizations have undertaken a community-wide or city-wide effort to conduct such an assessment, and then work collaboratively to address the overall health needs identified.

Whether the community collaborations and partnerships were formed around a community need already identified or a process of gathering data to identify the greatest needs, all of the collaborative efforts highlighted in this *Insight Series* have essential commonalities. They are an extension of hospitals' missions and commitment to the community, they fulfill an unmet need in the community and they rely on partnerships and collaboration to better identify and meet community needs.

- **Extending the Mission.** In all cases, the programs represent missions in action, extending hospital missions outside the hospital walls and into the community. Collaborative efforts build a more comprehensive understanding of the community's health needs and help all the partners to better address those needs together, such as better coordinated care, providing access to quality services at no charge and providing programs targeting specific unmet community health needs. In addition, the unique alignment of each of the partners' missions and goals strengthens the impact of the collaboration.
- **Improving Access to Care in the Communities Served.** The impetus for the majority of the programs came from a concern for the significant number of individuals in the hospitals' communities without adequate access to health care. Collaborative programs target access to care in specific areas such as communities with low immunization rates, lack of access to coordinated mental health services, shortages of dental clinics and management of asthma care. The majority of the programs then strive to measure the impact of the improved access, such as reduced emergency department visits or a reduction in school absenteeism.
- **Meeting Community Needs Through a Community Needs Assessment.** Several of the case examples feature community care partnerships in a city or region where hospitals and health systems have chosen to work collaboratively with public health to carry out a broad-ranging community needs assessment. In some instances, these partnerships have been fueled

or encouraged by the requirement for a community needs assessment included in the *Patient Protection and Affordable Care Act*. Organizations initiating a community-wide needs assessment agree that the process maximizes resources, helps all the key stakeholders to gain broader perspectives and insights into true community needs and sets the stage for a sustainable community collaborative to address needs jointly identified.

Partnering with Others

Meeting the community's health care needs has always been the highest priority for America's hospitals, but in today's evolving health care field hospitals recognize that they cannot achieve this objective alone. By partnering and collaborating with a wide variety of organizations, patients' needs are met more holistically, care is better coordinated and community needs are met in more deep and impactful ways.

- **Success Is the Result of Collaborative Community Partnerships.** Every partner provides valuable insight, perspectives and resources to the collaborative effort. It's not the level of contribution provided by each partner; rather, it is their presence at the table, an open mind, and a willingness to collaborate and contribute that creates the synergy and strength needed to address community needs.
- **Partners Meet Regularly.** Many of the collaborative partnerships meet regularly and have a defined structure. Some have a board or steering committee that meets monthly or twice a month, with subcommittees or working groups that focus on specific tasks and report their progress and findings back to the board or steering committee to ensure continuity and accountability.
- **Partners Are Many and Varied.** Each coalition of partners is unique to the community and program purpose. Coalitions are composed of individuals as well as public, private and not-for-profit organizations. Some are part of state-wide or metropolitan efforts, while others serve small communities. Partners include, but are not limited to, hospitals, medical groups and clinics, dental groups, county, city or state health departments and community service organizations. For all collaborations, the binding factor is a goal to change people's lives for the better.
- **Health Departments Are Active Partners.** Health departments, whether state or local, can provide strong support including access to registries for record keeping and data analyses, production of public messaging and coordination with broader efforts outside the local community. Health departments also may be a clearinghouse or source for grants that contribute to the programs' financial sustainability.



- **Partnerships Change People's Lives.** When individuals being served need care beyond the specific services of a program, coalitions of diverse partners can leverage their networks of relationships to develop referral networks linking individuals to needed services, or expand the program, bringing in new partners to meet their clients' needs.

Role of the Hospital or Health System in the Partnership

- **Financial Support and Other Needed Resources.** In most partnerships, hospitals take the lead in providing a wide range of resources, including clinical space, office space, hospital staff, funding and other in-kind resources. In some collaborations featured, hospitals' knowledge of quality improvement processes contributed to effective protocols, measurement of outcomes and validation of program effectiveness – all of which contribute to program viability and sustainability. These factors also help support applications for grant funding.
- **Primary Convener and Facilitator.** Hospitals often act as a “convener” to bring together all of the key partners. This may include facilitating the development of a partnership's infrastructure (such as mission, goals, etc.), hosting partnership meetings, reaching out to form new partnerships with other community organizations, providing education and training of program staff or care teams and more. Despite the often-primary role that hospitals play, hospital leaders agree that while they serve as the convener, they do not independently set the agenda nor drive program recommendations – this should be done when the full group is together and every stakeholder's opinion is given equal weight.

Measuring and Communicating Success

Where possible, all of the programs strive to be data-driven, measuring and tracking results to ensure progress toward goals and advancement of the program's long-term success.

- **Improved Health Measurements/Outcomes.** In addition to measuring increases in access to care, programs have improved community health status through decreases in tobacco and substance abuse. Several of the collaboratives developed task forces or working groups to further address and advance findings identified in their community needs assessments.
- **Care is Better Coordinated.** Collaborative programs are resulting in care that is better coordinated, minimizing duplication and resulting in more well-rounded, holistic care. Organizations agree that their partnerships have helped break down traditional “silos” between care providers, public health and community organizations. Collaboration results in support, broader perspectives and elimination of overlap between projects and programs. By working together, community constituencies can brainstorm and achieve outcomes they could not accomplish independently.

- **Communicating Impact.** While making an impact is important, program leaders also agree that successful communication of that impact can be a powerful tool. Many organizations post information about their community health initiatives on websites. Several organizations hold community meetings to announce their initiatives and share results. They also are able to gain community input for next steps, initiate other partnerships and identify related efforts. A concerted effort for transparency builds greater community support and trust, raises awareness of the programs and can help garner additional financial support.
- **Measuring Impact, Demonstrating Value.** Organizations conduct community needs assessments not only to identify community needs, but to measure the efficiency of existing programs and make adjustments when necessary. Hospitals and their partners continually seek evidence-based methods of evaluating the impact of their programs, which can be used to demonstrate results, set future goals and secure additional grant funding.

Funding and Sustainability

- **Resource Constraints are Ongoing.** Most of the programs receive grant funding, although the use of grant funds for daily operations varies widely. While most agree that grant funding is not a viable or sustainable strategy for long-term financing, it is most useful as a “start-up” source of funds. In many cases, hospitals provide dedicated resources, including cash donations, staff, office space and other in-kind donations. Other participating organizations provide resources when possible, but those resources tend to be few and limited.
- **Collaborative Relationships Strengthen Long-Term Sustainability.** Despite ongoing resource challenges, many organizations report that they are able to do more than before because collaborative efforts have led to a greater sharing of data and information, shared resources and a shared workload while reducing duplication. The nature of the collaborative relationships formed extends beyond community health initiatives, resulting in long-term working relationships with other organizations, public health and community agencies. As relationships strengthen and a wide variety of organizations become more invested in programs and initiatives, many organizations believe that financial and in-kind support will increase from a variety of sources.

Advice to Others

Program leaders offered advice about leadership support, fostering strong relationships and ideas for sustaining effective, impactful long-term collaborative partnerships.

- **Passionate Leadership is Required.** Passionate leaders help to kindle enthusiasm and inspire others to want to be a part of the mission and programs. Hospital leaders from the board room

PARTNERING WITH PUBLIC HEALTH

to the C-suite also can assist with community connections by forming strategic relationships in the community that break down barriers between the hospital and other organizations.

- **Foster Dialogue, Strengthen Relationships.** Collaboration begins with inviting those with shared interests to discuss current issues, efforts and challenges. A broad diversity of perspectives is essential, and hospital leaders are the ideal facilitators to bring together varying perspectives.
- **Collaborate on a Community Needs Assessment.** When hospitals and health systems along with public health departments begin a collaborative effort to conduct a community needs assessment it gives all partners a clear understanding of the challenges as well as identifies other potential partners that are affected by the shared community need.
- **Start Small.** The depth of community challenges and needs can be overwhelming. Focus on what you can do and recognize that the impact will not be overnight. In addition, avoid the temptation to group challenges together making the problem so large that it becomes cumbersome to address. The ability to identify, clearly articulate and substantiate a specific need and maintain an unwavering focus on the goals and outcomes identified to meet that need, are critical foundations to building a successful program.
- **Measure Return on Investment.** Estimating the costs saved by implementing a program or collaborative effort can help demonstrate the benefit to all stakeholders.

PARTNERING WITH PUBLIC HEALTH

CASE EXAMPLES

Bozeman Deaconess Health Services – Bozeman, MT

Community Health Needs Assessment Project

Impetus for Program

The Gallatin City-County Health Department approached their long-time collaborator Bozeman Deaconess Health Services about working together on a community health needs assessment. Quickly seeing the value in shared resources, Bozeman agreed. A third partner, the local federally qualified health center, also joined the effort. The groups brought a strong history of collaborative work to the needs assessment having already partnered on a successful flu immunization campaign and mobile health services outreach program. As Healthy Gallatin, Bozeman and the health department together applied for and received a grant allowing a more comprehensive assessment and additional resources that allowed community involvement for the resulting health improvement planning.

Mission and Hospital Role

As the main provider for a large geographic area, improving community health is central to Bozeman's mission. As such, a guiding strategy for the hospital is to leverage community expertise and resources through collaborations, building on existing programs when possible rather than creating duplication. Hospital leadership, including the board of trustees, is very involved in community benefit both as a concept and as a not-for-profit hospital responsibility. As a result, they are committed to meeting the needs identified and prioritized by the needs assessment even if that goes beyond the current scope of services provided.

Measuring and Communicating Success

As part of their community benefit involvement, the board and senior leadership set objectives that are regularly measured. Through its measurement, the hospital has seen significant improvements in most screening rates, including flu and glucose, as well as child immunization rates. As the priorities are set through the needs assessment, relevant measures will be incorporated to measure not just hospital impact but community-wide impact.

Funding and Sustainability

The Healthy Gallatin initiative is still finalizing its goals, objectives and related action plan with community partners. While it's unclear what programs will be enhanced or put in place as a result, Bozeman and its partners are committed to seeing the plan through.

Advice to Others

Collaboration opens doors to organizations in the community you may not usually work closely with and that can result in better outcomes for everyone. Working with a large group can be challenging and involving more people takes longer, but working together will result in a better, more impactful outcome.

Contact: Donna Cruz-Huffmaster, Planning and Business Development Manager

Telephone: 406-585-5000

E-mail: dcruzhuffmaster@bdh-boz.com

Children's National Medical Center – Washington, DC

Immunization Quality Improvement Initiative

Impetus for Program

The mission of the Goldberg Center for Community Pediatric Health, the primary care clinical center of excellence at Children's National Medical Center, is to build healthy communities. With five community-based health centers, two hospital-based health centers and three mobile medical units, the hospital program provides care for about 30,000 patients annually through 80,000 patient visits. One of the Goldberg Center's primary goals is to improve the delivery of preventive services to publicly insured children in the D.C. community. Recognizing that immunization rates serve as a proxy for children's well-being, there is a focus on improving childhood immunization rates.

Mission and Hospital Role

Though led by the Goldberg Center, the Immunization Quality Improvement Initiative is a highly collaborative project whose partners include the D.C. Department of Health, Child Health Advocacy Institute and D.C. Medical Assistance. Through its health centers, mobile medical units and other community-based services, Children's National Medical Center/Goldberg Center has a strong presence in the community and is well-positioned to improve the number of children immunized. An advantage for the immunization initiative has been the singular alignment of each partner's mission and goals of promoting and improving the community's health, particularly through services provided to the uninsured and underinsured.

Measuring and Communicating Success

In 2006 prior to implementing of the immunization initiative, the Goldberg Center's immunization compliance rate was 75 percent. Not only has the initiative successfully improved the center's

immunization compliance rate to 92 percent, it has sustained increases since its implementation. Through public/private collaboration, the Immunization Quality Improvement Initiative has successfully used quality improvement methodologies to achieve equity in care for these populations. The immunization registry maintained by the D.C. Department of Health's, Community Health Administration's Immunization Program, has been critical to the success of the data-driven program. The registry provides a tool for keeping children's immunization records updated, assessing completion of vaccine series, identifying needed follow-ups and preventing unnecessary immunizations due to lost records. The Goldberg Center produces and displays informational posters about vaccine-preventable diseases, school immunization requirements and additional information for patients and their families.

Funding and Sustainability

Project leaders are committed to this project, meeting monthly with representatives from each partner, including the D.C. Department of Health Immunization Program, the D.C. Medicaid health plans and physicians, nurses and administrators from the community-based health centers. These representatives identify barriers and challenges, explore strategies and introduce program changes designed to increase immunization rates.

Advice to Others

Organizations interested in increasing community immunization rates should start with a clear and specific idea of the desired outcome or goal. It is important to build upon existing partnerships and networks and recognize the essential inclusion of the Department of Health if it is not already a partner. Through passionate leadership and a persistent focus on outcomes, the initiative will be prioritized and valued by the organizations involved.

“Hardwire improvement processes into the organization's structure to ensure program and outcomes sustainability.”

*Contact: Denice Cora-Bramble, MD, MBA, FAAP, Senior Vice President, Goldberg Center for Community Pediatric Health
Telephone: 202-476-5857
E-mail: dcorabra@cnmc.org*

Hannibal Regional Hospital – Hannibal, MO

The Hannibal Free Clinic

Impetus for Program

In early 2005, a group of health care leaders in Hannibal recognized a shared concern for the number of residents without access to primary care. Stakeholders began to explore a variety of possible solutions to ensure uninsured and underinsured residents of the community received this essential service. A diverse coalition of organizations representing the hospital, county health department, medical groups and clinics, a dental group and community services organizations worked collaboratively to establish the Hannibal Free Clinic, an independent, community-based, 501(c)(3) organization.

Mission and Hospital Role

The mission of the Hannibal Free Clinic is “To promote health and wellness by providing quality services, at no charge, to people who are living in poverty without access to basic health care. This is accomplished by respecting the dignity of each individual; working collaboratively with volunteers; fostering community partnerships; and responding to current health needs of the community.”

The Hannibal Free Clinic is currently located in clinic space donated by Hannibal Regional Hospital and relies on the volunteer efforts of 12 medical staff (physicians, nurse practitioners and dentists) and 37 active volunteers. Hannibal Regional Healthcare System provides the clinic's only paid staffer, a clinical professional responsible for administrative oversight and volunteer coordination at the Free Clinic. The Hannibal Free Clinic's focus has been to provide non-emergent, primary care for uninsured individuals. When patients need specialty care beyond what the clinic can provide, the volunteer medical staff has leveraged its network of professional relationships to ensure patients receive the specialty care they need.

Measuring and Communicating Success

In a community with a population of about 18,000 people, the clinic has provided 6,220 visits for 1,206 unique patients since it opened. It also has enabled medication assistance for 6,747 prescriptions worth nearly \$4 million. Hannibal Regional Hospital links eligible patients needing hospital services with the hospital's financial assistance program; an administrator from the local county health department helped identify pharmaceutical companies' patient assistance programs to ensure the clinic's patients get the medications they need but cannot afford.



Funding and Sustainability

The consistent hours and availability of a paid administrator to coordinate the efforts of its volunteers has been essential to the clinic's successful operation. The collaboration and generous volunteer support of the medical staff and the community, pharmaceutical assistance programs and in-kind contributions, have enabled the Clinic to operate with only \$25,000 cash contributions in 2011. A recent grant from the Missouri Foundation for Health is enabling the clinic to grow and sustain its resources. The opportunity to move into a larger clinic space has afforded the Hannibal Free Clinic the chance to implement a five-year plan to add more dentists and much needed dental services capacity. It also gives the organization the chance to evaluate how it can best meet the community's need for mental health care as well as provide other needed services.

Advice to Others

Clinic representatives credit a keen and unwavering focus on a single unmet community need as the cornerstone of collaborative success. Passionate and influential physician and administrative leaders coupled with the collaborative commitment of volunteers and partners throughout the community have been vital to the clinic's successful operation. Additionally, clinic representatives recommend that others interested in establishing a free clinic investigate and fully understand statutes limiting liability for physician volunteers.

Contact: Julie Leverenz, Vice-President, Strategy and Planning, HRHS
Telephone: 573-406-1605
E-mail: Julie.leverenz@hrhonline.org

Kings County Hospital Center – Brooklyn, NY

Intensive Crisis Stabilization and Treatment Program

Impetus for Program

The Intensive Crisis Stabilization and Treatment (ICST) Program is a 12-week community or home-based treatment program for children in need of immediate mental health assistance. Part of the program's uniqueness is that it meets patients where they are, initially three times a week in their home, school or other community location. The program was developed to address the mental health needs of children ages 5-17 and their families in New York City (NYC) with the primary goal of preventing psychiatric hospitalizations.

Mission and Hospital Role

Meeting the community's needs has always been the highest priority for Kings County Hospital Center. The hospital is continually striving to find new ways to identify and meet community needs, and meeting patients where they are to provide critical care is important to the hospital. This program's ability to provide care to patients who are in the midst of a crisis, in the location that is most comfortable for them, ties in well with the hospital's community-centeredness. It services children and families in acute mental health crisis and was funded and supported by Kings County Hospital Center and NYC Department of Health and Mental Hygiene, with both organizations recognizing that the provision of services in the community and at home for children is the most effective way to reach them during crisis.

Measuring and Communicating Success

Because referrals can come from anyone in the city, ICST Program staff spend a significant amount of time working with community organizations to spread the word about the program. Staff participate in community health fairs and school outreach programs and make presentations to outpatient clinics, teachers, guidance counselors and others who may refer potential patients in need. This partnership not only helps address acute mental health needs that were overlooked in the past, but also works to break down barriers around mental health care. ICST Program partners work together to ensure that the treatment is successful and has a long-term impact. The program's success rate is high, with treatment adherence above 90 percent.

Funding and Sustainability

The ICST Program received grant funding in 2006 from the NYC Department of Health and Mental Hygiene and became operational and saw its first patient in 2007.

ICST Program staff are employed by Kings County Hospital Center. Currently the program is partially grant funded and partially funded by the hospital. The three-year grant is renewable three times; in 2015, the nine years will be complete. At that point, the program will continue to seek alternative grant funding. Service reimbursement by Medicaid and third-party payers has begun to catch up with this service delivery model and there are some indications that the program may become self sufficient.

"The program's clinical success thus far has demonstrated that collaborating with public health, other agencies and individuals in the community is essential. In the future, the ICST Program and Kings County Hospital Center will continue to seek out innovative partnerships to better enhance patient care."

Advice to Others

Hospital leadership support is essential to ensure that the program has the resources necessary to be successful. Essential hospital support comes in the form of financial resources, as well as in-kind resources and leadership support and flexibility for ICST Program staff. Program staff must be personally committed to the work they are doing, because most of the time is spent in the field independently interacting with patients.

Because the program's success is dependent on multiple organizations working together, maintaining confidentiality and HIPAA can be a challenge. Remain mindful of privacy when sharing necessary treatment information.

Contact: Lana Krichmar-Liverant, PhD, Director, Intensive Crisis Stabilization and Treatment Program
Telephone: 718-245-2519
E-mail: Lana.Krichmar-Liverant@nychhc.org

Mt. Ascutney Hospital and Health Center – Windsor, VT

Substance Abuse Prevention Program

Impetus for Program

More than 10 years ago, a community assessment identified a high incidence of chronic respiratory problems and cancer. Mt. Ascutney Hospital and Health Center (MAHHC) wanted to take a preventive approach, which led to first addressing tobacco cessation, then substance abuse reduction and prevention. Initially MAHHC approached an area school, but quickly broadened the group to include public health, social service agencies, police and recreation departments and others when there was consensus around tobacco and substance abuses as key concerns.

Mission and Hospital Role

The effort reaches out to students from the hospital's surrounding community with programs and campaigns to help strengthen families and guide good choices; a natural expression of Mt. Ascutney's strong belief that as a small community hospital, there is real opportunity to influence health. At its heart the program is a community partnership with the infrastructure consisting of a series of coalitions related to specific areas of focus. This approach has worked well, enabling a targeted, yet multifaceted approach. Early on, participating groups developed by-laws, a formal mission, and goals and began creating an annual report. The structure served as an anchor and made some things easier, providing clear commitment and a clear statement.

Measuring and Communicating Success

Evaluation is key and when possible, existing community health indicators have been adopted as key measures. The program conducts its own life skills survey annually after its evidence-based curriculum. The hospital also has worked with an external evaluator to give an important degree of separation and validation. The program has made significant progress in decreasing tobacco use among 8th-graders and decreasing high-risk behaviors of substance abuse among eighth through 12th-grade students in four area communities. This fact is one the community celebrates and all community partners share and promote publicly.

Funding and Sustainability

MAHHC drives much of the program's longevity and sustainability but has worked with partners including public health to successfully identify and apply for grant funding, administer awarded funds and report as needed to funding agencies.

Advice to Others

Taking time to hear and understand others will build trust and serve as a catalyst for change. Help partners recognize that by working together, resources can be shared and much more can be achieved than when working alone. Related, work to break down silos of preconceived opinions on who does what – everyone needs to work together. Identify key stakeholders like local public health departments, and set up meetings to identify common needs and partnership interest. Allow stakeholders to inform your thinking. Don't approach partners with a fully formed program in mind; instead, state the challenge and ask how it can be fixed?

"Give away success. Often a hospital is a key leader from the start, but whatever is achieved is done so by the community. Recognize partners often and the impact the group has had on addressing the unmet health need. No one could achieve the success alone."

Contact: Jill Lord, RN, Director of Patient Care Services/
Chief Nursing Officer
Telephone: 802-674-7224
E-mail: jill.lord@mahhc.org



Norwalk Hospital – Norwalk, CT

Community Health Needs Assessment Project

Impetus for Program

When looking in-depth at the assessment rules associated with health reform, Norwalk Hospital recognized two big challenges: how does one hospital tackle the wide-ranging requirements and where can resources be found for such an endeavor? The public health director was of the same mind and the two longstanding collaborators quickly decided to work together. Local leadership enthusiastically supported a broad approach that looked beyond traditional “community” boundaries and all area public health directors were contacted. The wide net grew from there.

Mission and Hospital Role

Norwalk Hospital and the Norwalk Department of Health partnered to conduct a community needs assessment. The hospital’s Board of Trustees wanted to better measure unmet community needs and direct activities to enhance the impact on community health improvement. The result was a new Community Health Committee made up of trustees and community partners. At the start, the hospital and the health department disclosed their respective legal and accreditation-related requirements. However, neither organization sets the agendas nor drives the recommendations; instead, they serve as facilitators. The group set a mission for the project and eagerly offered data, focus group assistance and other needed aid.

Measuring and Communicating Success

The community needs assessment was shared broadly and has received input from many community stakeholders – most participating in the ongoing group meetings. While the Norwalk area was found to be fairly “healthy” with many assets, the group did identify three priority areas for improvement: mental health, substance abuse and obesity. The larger group self-divided into smaller working groups focused on each priority area and are in the process of refining goals and objectives that will inform measures for success.

Funding and Sustainability

The health department secured a grant to cover consultant services and the hospital committed funds to cover the remainder of associated costs, a challenge but also a necessary investment. Community partners were asked to join and contribute their expertise, relevant data and leadership. The first meeting included almost 150 individuals from organizations including catchments area public health departments, behavioral health associations,

service providers, the faith-based community, the Chamber of Commerce and local businesses. It’s too early to say what specific measures will be used to track success, but all parties believe measurement yields sustainability. The open attitude has resulted in willingness from all parties to share information and workloads and approach community challenges as an opportunity to work together.

Advice to Others

This partnership between the local hospital and health department has been a rewarding experience for all parties and has enabled the hospital to broaden and deepen their relationships with community partners across our service area.

“When there are issues that impact community health, we want and need to be at the table. Including as large a network of participants as possible helps to position the hospital as the community health leader, and I am hopeful that there won’t ever be a time we don’t collaborate.”

Select the most important community needs and “don’t try to boil the ocean.” Empower community partners to set an improvement agenda with measurable outcomes so that the partners are on board to both participate in and own the plan. Break the improvement plan down into specific goals with strategies for each. Too big a problem becomes overwhelming to address.

Contact: Mary Franco, Vice President, Public Affairs

Telephone: 203-852-2422

E-mail: mary.franco@norwalkhealth.org

Parkview Health System, Inc. – Fort Wayne, IN

Asthma ER Call-Back Program

Impetus for Program

In July 2009, Parkview Health System set out to address asthma, the number one reason for school absenteeism, which in turn often causes parents and caregivers to miss work. Asthma also is the reason many adults and children are seen in the emergency department (ED). In fact, according to national statistics, those who are seen in EDs three or more times in a year or are hospitalized two or more times in a year for asthma are more likely to die than those whose asthma is better controlled. Parkview Hospital, in partnership with the Indiana State Department of Health, designed its program

to address these concerns. Focused on reducing the costs of asthma and improving quality of life, the multi-year State Asthma Plan is built on the collaboration of individuals and public, private and not-for-profit organizations throughout the state of Indiana.

Mission and Hospital Role

Parkview Hospital's Asthma ER Call-Back Program provides the education and resources that many individuals and families coping with asthma lack. Patients who are admitted via or discharged from Parkview's ED with a primary diagnosis of asthma are contacted following their discharge. During the call, patients are asked about the status of their asthma, if they understand their discharge plan, if they've filled prescriptions and if they've made follow-up appointments with a physician. Educational information is shared to strengthen patients' understanding and management of their asthma. If patients don't have a primary care physician or medical home, a Parkview asthma educator assists them in accessing their local federally qualified health clinic. To ensure patients get the care and medications they need but may not be able to afford, Parkview's asthma program connects uninsured patients with the hospital's financial assistance program and medical assistance program.

Measuring and Communicating Success

Parkview Hospital is working with the Indiana Joint Asthma Coalition, including an epidemiologist, to quantify the program's results. Over a two-and-a-half-year period, the program has provided 1,200 contacts either via phone or mail and distributed 1,700 pieces of asthma literature. The Parkview Hospital's Asthma ER Call-Back Program conducts a periodic survey of program participants.

Funding and Sustainability

The hospital credits the collaboration with its community partners for the program's success. The Allen County Asthma Coalition supplies the program with educational materials. Through generous donor support, they are able to purchase pillow and bed encasements. Medical interpretation for Burmese families was made possible by a coalition of local health organizations including the Fort Wayne-Allen County Health Department. Grant dollars from the Indiana State Department of Health contribute to the program's financial sustainability.

Advice to Others

Start with strong, collaborative relationships with community partners as a starting point. Regardless of the level of contribution, a presence at the table, an open mind and the willingness to collaborate and contribute creates the synergy and strength needed to successfully address a community's needs. The hospital must be a part of the community to work within the community. The hospital cannot be effective working in isolation; the success of the asthma program is the result of collaborative community partnerships, private and public combined.

Contact: Connie Kerrigan, Community Nursing and Women's Services Manager

Telephone: 260-373-7991

E-mail: connie.kerrigan@parkview.com

Spectrum Health – Grand Rapids, MI

School Health Advocacy Program

Impetus for Program

Together, Spectrum Health and an area school decided to bring health services to students directly – within the walls of the school. Since 1995 the program has expanded, and recently Spectrum Health brought different stakeholders to the table – other health organizations, nonprofits, public health department and others – to conduct a county-wide community needs assessment leveraging each group's area of expertise. Today, a health care team of school nurses, community health care workers and school staff provide on-site clinical services and health education to all students.

Mission and Hospital Role

Spectrum Health is involved in many programs that benefit the community and all revolve around the organization's mission: to improve the health of the community. Before a School Health Advocacy program begins, Spectrum Health, community health partners and individual schools conduct a joint needs assessment identifying the unmet health needs of the students. From there, the health system works closely with the school to determine the best fit for staff, students and the community. Spectrum Health coordinates all education and training of the care team to ensure the care delivered is safe and appropriate.

CASE EXAMPLES



Measuring and Communicating Success

In the 2011-2012 school year, the program provided services to 28,168 children across 56 schools and more than 97 percent of students met immunization requirements. The program provided more than 10,000 vision screenings giving roughly 1,400 referrals, with more than half of the referred students getting glasses. Almost 5,000 children were diagnosed with medical conditions including asthma and diabetes. More than 170 children were referred to protective services through the program RN, and 166 of these children had a school support plan in place.

Funding and Sustainability

Grant funding is not sustainable and often limited in how it can be used, but it's been useful as a "start up" source of funding for new school programs. Taking the time to identify the specific needs of each school population allows for a collaborative and tailored assessment – often resulting in schools and other partners assuming some of the costs associated with providing a health care team. It also is important to look at the ROI for the school system, such as improved attendance, which leads to better learning, better behaviors and ultimately improved outcomes. In addition through partnerships, mandated accommodations for students with significant health issues can be met together and in a more cost-effective way with better resource utilization.

Advice to Others

Start with a broad community needs assessment and identify potential community partners like public health that are being impacted by a shared challenge. Spectrum Health's community needs report found an increase in childhood obesity and related chronic diseases. Schools were experiencing related challenges – absenteeism and associated decreased funding. It was a natural partnership for Spectrum to enter into. Also, conduct school specific needs assessments to tailor specific program goals. While difficult to measure, make the case for ROI. For example, identify the cost for a diabetic child to come to the hospital or the emergency department experiencing an asthma attack. Extrapolate to demonstrate what is being saved when those cases are prevented.

Contact: Erin Inman, Director, Healthier Communities

Telephone: 616-486-6549

E-mail: erin.inman@spectrum-health.org

St. Charles Health System – Bend, OR

Behavioral Health Consultant Program

Impetus for Program

A diverse group of Oregon health groups reimagined coordinated care that combined the physical and mental health of individuals. After a "white board" community needs assessment, the group identified strategies to quickly impact health and rein in costs, packaging it as a pilot project complete with state public health funding. The Health Integration Project oversaw three programs: one focused on managing care for frequent emergency department visitors; another helping individuals access mental health services; and a third supporting families who may have special needs children. From its inception, the public-private partnership has worked for and achieved policy changes, frequently through legislation. Both the scope of programs and participating partners have grown, but its mission remains unchanged.

Mission and Hospital Role

Participation involves key leaders from each group including county commissioners and CEOs. Early into the group's existence, it was decided that while the size of partners varied, everyone's vote was equal and that what the group decided was legally binding. Success relied on everyone's full commitment and participation. A supporting board engages other leaders from these organizations such as public health directors and community mental health directors. For several years, these groups met weekly. Early into the Behavioral Health Consultation Program's creation, St. Charles saw its value – not only related to community benefit but the broader goal of achieving better community health – and provided a loaned executive to the project to oversee. As the program grows, additional resources will be funded by a portion of the region's Medicaid spending.

Funding and Sustainability

Measurement currently demonstrates that program participants receive better care when mental health is included, but there is a desire to include measurement that demonstrates the program impacts better health. Patient assessments allow for some of that, but moving forward the hope is to capture more tangible results. Participation has helped organizations recognize the community's assets and work to avoid duplication. Instead, there's collaboration (a public-private partnership that included local government, St. Charles Health System, the region's managed care organization, safety net clinics and the Oregon Health Authority) to create infrastructure so existing services or programs can better meet an identified need without the struggle of proprietary issues. The program is required, by law, to provide a health improvement plan every four years. This is a natural fit for their self-directed goal of promoting health for the

PARTNERING WITH PUBLIC HEALTH

region's residents through improving outcomes, increasing satisfaction with the health system and reducing costs. The related health needs assessment is routinely shared publicly and free online.

Advice to Others

Open your doors and invite people to lunch. Collaboration works best if the hospital does not go in telling partners what the community's needs are; rather, start conversations, listen and keep those conversations going. Successful partnerships are about relationships. It's hard work, but take the time to begin and build relationships at both the CEO level and senior director level. When everyone involved recognizes themselves as a peer, the hard work becomes more doable.

Contact: Robin Henderson, PsyD, Acting Executive Director, Central Oregon Health Council

Telephone: 541-706-2791

E-mail: rhenderson@stcharleshealthcare.org

St. Francis Hospital/ Dignity Health (and all San Francisco Area Hospitals) – San Francisco, CA

Building a Healthier San Francisco Coalition and the Community Benefit Partnership

Impetus for Program

BHSF is a city-wide collaborative of non-profit hospitals, the San Francisco Department of Public Health, McKesson Foundation, San Francisco Foundation, United Way of the Bay Area, Metta Fund, Blue Cross of California-State Sponsored Business and a variety of health organizations and philanthropic foundations. The cooperative effort was established in 1994 to conduct a community health needs assessment for San Francisco, which is now conducted every three years. The Community Benefit Partnership seeks to harness the collective energy and resources of San Francisco's private non-profit hospitals, city departments (Public Health and Human Services), community clinics, health plans, non-profit providers and advocacy groups to improve the health status of San Francisco residents.

Mission and Hospital Role

The city-wide effort aligns with each of the hospitals' missions and visions in varying ways. For St. Francis Hospital, the partnership fits perfectly with the hospital's commitment to the community, as well as the community commitment of its parent organization, Catholic Healthcare West. All of the participating hospitals believe in the

importance of this collaborative effort and receive top leadership and board support. San Francisco has a unique culture of participation and collaboration, and this collaborative partnership is no different. While all the participating organizations have had positive relationships in the past, the renewed strength of the initiative in recent years has further strengthened the relationships between the key players and renewed a city-wide commitment to community-based planning.

Measuring and Communicating Success

The collaborative efforts have broken down traditional "silos" and "fences" and helped each of the organizations to support one another in their work. As the groups increasingly work together, leaders are able to identify and capitalize on cross-pollination between projects and programs. Each meeting brings to light new, broader implications and the realization of the overlap and alignment between the good work already going on across the city, as well as the desire of all the key players to work together, share information, and address community needs in a collaborative manner. When the Community Vital Signs report was unveiled at the 2010 Community Needs Assessment Breakfast, the breakfast hosted more than 300 community stakeholders and was featured on the front page of the *San Francisco Business Times*.

Funding and Sustainability

Because of the commitment from the area hospitals, the group has a collaboration of organizations working together to ensure stable funding. The hospitals' CEOs are committed to the effort and they provide in-kind donations, staff time and financial contributions to support the work. The partnership is currently in the process of developing its community health improvement plan for the city based on the recent assessment findings. Much of the implementation will capitalize on the work already being done across the city, including existing programs and program champions. Along with this renewed focus, moving forward the partnership will continually face the challenge of resource constraints. The intent of the partnership's new efforts is to focus on fewer initiatives, with a renewed emphasis on areas that have the potential to make the greatest impact on the community. In a community with high stakeholder participation, limiting the number of focal areas may present some challenges.

Advice to Others

Starting a city-wide partnership begins with fostering dialogue, inviting those with a shared interest to come together to discuss current issues and challenges, as well as efforts already underway. Hospitals must recognize that it takes time to form strong relationships and that a broader diversity of perspectives is essential. Health care leaders can learn the most by bringing community leaders to the table with varying perspectives, creating a more well-rounded view that inevitably results in common ground with the community at the focal point.

CASE EXAMPLES



When a collaborative group is ready to conduct a full-scale community needs assessment, be prepared that the results can be overwhelming when leaders recognize the extent of the problems present. Don't get lost in the data; it is important to focus on what you can do, rather than what you cannot do. In addition, leaders must recognize that none of the solutions are overnight and require a long-term commitment.

Contact: Abbie Yant, Vice President for Mission, Advocacy and Community Health

Telephone: 415-353-6630

E-mail: Abbie.yant@dignityhealth.org

St. Joseph's Hospital (Hospital Sisters Health System) – Chippewa Falls, WI

Chippewa Health Improvement Partnership

Impetus for Program

The Chippewa Health Improvement Partnership (CHIP) was first formed in 1994, when the hospital brought together a cross-section of 25 community representatives including public health to undertake a community needs assessment. The CHIP mission is “a collaborative community endeavor serving as a catalyst for the enhancement of community health and quality of life through educational and preventative initiatives.” A collaboration of more than 100 volunteers is involved in Steering Committees and Action Teams that address specific community health needs identified across the county.

Mission and Hospital Role

CHIP is an ideal extension of the hospital's mission to provide quality care for those in need. The broad base of partners helped the hospital to build a more comprehensive understanding of the community's needs and to fill those gaps most effectively. CHIP is viewed within the organization as a mission-accountability that weaves the hospital's mission into the fabric of the community. The primary host for CHIP is the hospital, but the partnership is governed by a steering committee composed of a broad range of community representatives. CHIP receives financial and in-kind support from St. Joseph's Hospital, as well as from state, federal and local grants that support specific projects undertaken by CHIP.

Measuring and Communicating Success

CHIP conducts community needs assessments regularly and uses the results to measure the impact of its efforts. In addition to the community needs assessment, CHIP frequently reviews public health data already available, such as data from a youth risk behavior survey conducted every two years and county health rankings. Participation

in individual CHIP programs and initiatives is tracked as well, and CHIP constantly strives to develop additional evidence-based methods for evaluating the impact of programs. The hospital posts community needs assessment results on its website, as well as the implementation plan to address specific identified needs.

Funding and Sustainability

The nature of the collaborative relationships formed by CHIP has extended beyond community health initiatives and has resulted in sound working relationships with the other community agencies. And although the hospital is the primary funder of the program, CHIP is a community endeavor where all community agencies, organizations and other stakeholders are welcome and encouraged to participate. This participation is now extending, as CHIP is expanding its outreach to beyond the county and considering the impact it may have in Western Wisconsin.

Advice to Others

Having a program champion is critical. The individual championing the program must be in the community continually networking and building relationships, which requires administrative support and buy-in. Hospital administrators must understand that connecting with the community is the first step to building community health and that takes time. They also can assist with community connections, forming strategic relationships in the community that break down barriers between the hospital and other organizations.

“No one agency can affect health change individually; it requires a partnership of multiple organizations often including hospital and public health. Forming those trust-based partnerships takes time and a commitment from all the key players.”

Once a partnership is in place, communicating with the community is vital. CHIP posts the results of its community needs assessment on the hospital's website, and also has a separate CHIP website that provides detailed information about community health initiatives underway. Social media is used also to connect with the community and invite people to become a part of CHIP.

Contact: Rhonda Brown, Regional Director of Community Health Development HSHS Division (Western Wisconsin); Director of Chippewa Health Improvement Partnership

Telephone: 715-717-7647

E-mail: rbrown@sjcf.hshs.org

UMass Memorial Health Care – Worcester, MA

Healthy Options for Prevention and Education (HOPE) Coalition

Impetus for Program

The HOPE Coalition is a teen-led group that tackles community health challenges from smoking to mental health that began in 2000. UMass Memorial Health Care has a strong commitment to preventing youth violence, and HOPE presented an excellent opportunity for the organization to support its commitment while partnering with other stakeholders. HOPE aims to increase youth leadership, involve more youth in decision-making processes, and reduce youth violence, substance abuse and smoking in order to make the City of Worcester a healthier place for young people to live and grow.

Mission and Hospital Role

At-risk youth are a priority for UMass Memorial Community Benefit programming and the hospital credits HOPE with reducing youth violence and smoking while nurturing youth leadership. UMass Memorial's participation is part of a long-term commitment to area youth – through both improving their health and valuing their voice. HOPE members are active in helping the hospital identify community needs through participation in needs assessments, focus groups and community improvement plans. UMass Memorial committed direct funding of an executive director for HOPE and provided office space as well as staff support. All partner organizations and agencies, including UMass Memorial staff, participate in an advisory board that also provides leadership for the coalition.

Measuring and Communicating Success

Through the provision of a Youth Worker Training Institute for counselors in youth organizations, HOPE successfully lowered common teen barriers to accessing mental health and substance prevention services, and other social support services. Additionally, HOPE was successful in spearheading a citywide policy strategy against tobacco advertising with the goal of impacting policy change. Repeated presentations to city leaders and city council meetings led to a ban of tobacco advertising from streets, parks and schools and a ban of sales at pharmacies.

Funding and Sustainability

Today, HOPE continues to be teen-led and teen-powered, leveraging its own funds for programming while relying on its 18 community partners including mental health agencies, Worcester Public Schools, public health and others for a diverse funding stream. UMass Memorial is a financial anchor for this coalition, while ensuring HOPE's leadership. Some coalition partners provide in-kind staff to train HOPE's peer leaders. The coalition also seeks opportunities to leverage funds through collaborative efforts.

Advice to Others

It is critical to value and respect the work of the community. Hospitals are good at providing care and taking care of health problems, but others may be better placed to address related problems that are happening downstream. Working together will maximize the impact. As a health organization, give partnerships trust and respect. Let the coalition have autonomy to work things out. Support the goals and activities they set – do not impose the hospital's agenda.

Do not underestimate the possibilities of what a group of empowered and knowledgeable youth can do to impact “real change.”

“Solid research, data-driven advocacy campaigns to the public and local government, and personal testimonials like those conducted by the HOPE Coalition can energize long-term efforts such as policy changes.”

Contact: Monica Lowell, Vice President, Community Relations

Telephone: 508-334-7640

E-mail: monica.lowell@umassmemorial.org

CEO **INSIGHT** SERIES: Community Partnerships

SUMMARY/CONCLUSIONS

Deeply rooted in their mission, hospitals' commitment to improving the health of their communities is a logical extension of their direct, daily patient care activities. Today's health care environment is one of challenge, change and complexity, the magnitude of which can, at times, seem nearly insurmountable. Yet, through collaborative efforts and unique partnerships, many hospitals and health systems are successfully promoting better health and better health care.

The programs featured in this CEO Insight Series provide examples of the many ways hospitals can collaborate successfully with local community organizations. Although each program is uniquely designed to meet the needs of its community and to leverage the structure and resources of the hospital and partners involved, many commonalities and themes are found among them. Leadership from all participating organizations, but particularly from the hospital or health system, is critical. Hospital leaders and board members demonstrate their support and commitment by ensuring the allocation of resources and time necessary to ensure program success. This leadership commitment is a catalyst that encourages support from hospital employees, local physicians and the community as a whole.

The positive outcomes and trends found throughout this publication demonstrate that hospital/community partnerships are delivering improved access to preventative and coordinated care, improved community health and a better quality of life for many community residents. We hope these programs will both inspire and provide help and guidance to hospitals and health systems seeking to engage local organizations in collaborations and partnerships to promote a higher quality of health for their communities.

A robust version of each case example described in this publication may be found on our website, www.ahacommunityconnections.org. For more detailed information about a specific program, the contact information for individuals at the featured hospital or health system is included with the case example.

Index

Bozeman Deaconess Health Services 7

Children’s National Medical Center 7

Hannibal Regional Hospital 8

Kings County Hospital Center 9

Mt. Ascutney Hospital and Health Center 10

Norwalk Hospital 11

Parkview Health System, Inc. 11

Spectrum Health 12

St. Charles Health System 13

St. Francis Hospital/Dignity Health and all San Francisco Area Hospitals 14

St. Joseph’s Hospital 15

UMass Memorial Health Care 16



If you have a program you are proud of
and want others to know about,
please visit www.ahcommunityconnections.org
to submit a case example.



**American Hospital
Association**

American Hospital Association
155 North Wacker Drive
Chicago, IL 60606

Liberty Place
325 Seventh Street, NW
Washington, DC 20004-2802

www.aha.org
(800) 424-4301

© 2012 American Hospital Association

November 2012