Creating Effective Hospital-Community Partnerships to Build a Culture of Health

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Executive Summary

Effective and sustainable hospital-community partnerships are critical to building a Culture of Health. Building a Culture of Health means creating a society that gives all individuals an equal opportunity to live the healthiest life they can, whatever their ethnic, geographic, racial, socioeconomic or physical circumstances may be.

To understand the variety of ways that hospitals and communities can develop and sustain partnerships, the Health Research & Educational Trust (HRET), with support from the Robert Wood Johnson Foundation (RWJF), conducted 50 interviews with hospital, health system and community leaders from 25 diverse communities. These interviews resulted in lessons learned and best practices in identifying community health needs, potential partners, and sustainable partnership structures, as well as recommendations for overcoming obstacles and challenges and assessing partnerships.

Though some partnerships develop organically, a catalyst event – such as the initiation of a community health needs assessment process, new policies or payment models, or emerging community health issues – often brings organizations together or revitalizes long-standing partnerships. Hospitals and health systems also are seeking out new and nontraditional partners, such as grocery stores, food banks, 2-1-1 centers and local police departments, to address a wide range of community needs.

As new partnerships form, there is a need for increased structure and effective operations for the partnerships. It is critical to define goals based on the community's health needs when building an effective partnership. When partners come together to address an identified priority health need of the community, the goals and objectives of the partnership should be agreed upon and understood by all partners. The most appropriate governance and organization structure can then be developed, with all partners understanding their distinct role in the collaborative approach to addressing their community's health needs. Shared governance can take the form of steering committees, advisory boards, joint ventures, coalitions and a variety of more informal structures. With a strong organizational structure and identified goals, objectives and roles, these partnerships can effectively develop evidence-based interventions.

Creating effective partnerships within communities also includes evaluating the interventions and the partnership itself. Successful partnerships, including those highlighted in this guide, evaluate the effectiveness of their interventions by using process and outcome metrics. Additionally, hospitals and community organizations are beginning to assess the effectiveness of their partnerships through surveys and such resources as coalition member assessments.

Hospital-community partnerships face some common barriers and challenges, including limited funding, lack of structure, differing organizational cultures, disparate data collection and storage, limited operational resources, and the need for leadership and organizational buy-in. Overcoming these barriers and challenges is necessary to have a positive impact on the effectiveness and sustainability of the interventions. Using a systematic process for forming effective partnerships will ensure that all functions and operations for the partners are identified and established. These functions include structure, communication, representation, funding and other partnership activities.

Figure 1 outlines strategic considerations for creating an effective and sustainable hospital-community partnership to build a Culture of Health.

Figure 1: Strategic Considerations for Creating an Effective and Sustainable Hospital-Community Partnership

Partnership Leadership and Governance
Develop an informal or formal governance/steering group (e.g., coalition, board, committee) with individuals representing each partner organization.
Obtain support and commitment from each partner's CEO, senior management team, board of trustees and other key leaders.
Develop succession plans with current and future leaders so the partnership does not rely entirely on one person or organization.
Get agreement with all partners on mission, vision, goals, objectives and appropriate intervention strategy.
Draft any legal agreements or memorandums of understanding to solidify the partnership structure, as needed.
Present return-on-investment case to leadership at all organizations.
Partnership Structure and Culture
Clearly define roles and responsibilities of each partner.
Convene active workgroups and committees that focus on execution and continually work to address challenges and barriers.
Engage partners in collaborative problem-solving of jointly shared problems.
Discuss lessons learned on an ongoing basis to modify and strengthen partnership structure and processes.
Ensure transparent and frequent communication between partners and other key stakeholders.
Regularly conduct informal reviews (e.g., Plan-Do-Study-Act cycle) of partnership quality to identify any areas for improvement.

Partnership Program Development and Implementation
Identify health needs through a community assessment, with participation or input from key partners. Develop programs based on prioritized community health needs.
Ensure partners agree on the scope of the interventions (e.g., focus on a few targeted conditions/drivers or a comprehensive range of health and sociological issues).
Identify any evidence-based interventions and promising practices for the identified need, and agree upon process and outcome metrics.
Identify community assets to determine all available resources (e.g., financial, time, facility space, staff, IT, in-kind or other resources) and potential partners.
Identify and apply for secure, sustainable funding. Consider pilot grants if long-term funding is unavailable.
Tracking Partnership Outcomes
Adopt a partnership assessment survey tool to periodically gauge partnership satisfaction.
Measure the impact of the partnership's efforts on the stated goals. Select process measures to signal progress toward the long-term goal.
Share data among partners, particularly data on partnership goals.
Share data with community stakeholders and community members to demonstrate progress.
Ensure that partners measure the perceived quality and impact of the partnership to improve health.
Evaluate how the partnership facilitates ongoing community relationships.
Celebrate successes and communicate stories broadly.

Source: HRET, 2016.

Effective partnerships are important in building a Culture of Health in a community. This leadership guide summarizes a range of approaches that hospitals, health systems and communities have used successfully; provides a framework for building effective partnerships; and describes approaches to evaluating partnerships. Promising practices presented in this guide highlight the importance of leadership, mutual understanding and alignment of goals, common terminology, and transparent communication to cultivate effective partnerships and build a Culture of Health.

Introduction

With the passage of the Affordable Care Act and the adoption of value-based payment models, hospitals and health care systems are being challenged to improve the health of the communities they serve. To successfully improve the health of populations, it is necessary to address the drivers of health, including socioeconomic factors, health behaviors and the physical environment.

Hospitals and health systems are ideally positioned to improve the health of their communities. Not only do they have expertise in improving health, most hospitals are one of the largest employers in their communities and have established strong reputations as major community stakeholders. The scope and multifaceted approach necessary to improve the health of communities is not a task that can be undertaken by a single organization or sector alone. Each organization working independently can have an impact, but by partnering with other organizations around a shared goal, the impact can be much greater. This collaborative approach among partners is essential to build a Culture of Health: a society where all individuals have an equal opportunity to live the healthiest lives they can, whatever their ethnic, geographic, racial, socioeconomic or physical circumstances happen to be.

Cross-sector collaborations to improve community health are becoming widespread across the United States, with many hospitals and health systems playing a key role. Though the impetus for initiating such collaborations varies, the result is clear: Everyone can make a bigger impact if they work collaboratively rather than independently. This approach is sensible because, in many cases, the various community organizations are working on related issues or are targeting the same populations, creating an opportunity to align efforts, reduce duplication and silos, optimize financial resources and, ultimately, improve the overall health and well-being of the community.

While it is widely accepted that a collaborative approach between hospitals and community stakeholder organizations is key to building a Culture of Health, developing and sustaining collaborations remains a challenge for many. As part of the Robert Wood Johnson Foundation's (RWJF) vision to build a Culture of Health, the Health Research & Educational Trust (HRET), an affiliate of the American Hospital Association (AHA), is seeking to advance hospital-community partnerships by learning how hospitals and community partners develop effective collaborations and how these partnerships are measured.

A Culture of Health is a vision where:

»   Good health flourishes across geographic, demographic and social sectors.

»   Attaining the best health possible is valued by our entire society.

»   Individuals and families have the means and the opportunity to make choices that lead to the healthiest lives possible.

»   Business, government, individuals and organizations work together to build healthy communities and lifestyles.

»   Everyone has access to affordable, quality health care because it is essential to maintain, or reclaim, health.

»   No one is excluded.

»   Health care is efficient and equitable.

»   The economy is less burdened by excessive and unwarranted health care spending.

»   Keeping everyone as healthy as possible guides public and private decision-making.

»   Americans understand that we are all in this together.

Source: Robert Wood Johnson Foundation, 2015.

In a past project with RWJF, HRET developed "Hospital-based Strategies for Creating a Culture of Health." A key approach to building a Culture of Health is the development of multisectoral partnerships to collaboratively address priority health needs within the community.

To further explore collaborative approaches for building a Culture of Health, HRET and RWJF researched the elements of successful partnerships between hospitals and community-based organizations. This leadership guide elaborates on the elements of effective partnerships and provides recommendations on developing and maintaining successful partnerships between hospitals and community stakeholders.

The recommendations in this guide are informed by:

»   Fifty interviews with leaders from hospitals and community organizations, selected from a diverse sample of 25 communities, to determine common themes and approaches for developing effective collaboration. Communities were selected based on a population health survey administered in 2015 by the Association for Community Health Improvement, a division of the AHA.

» Analysis of the interviews to capture targeted health priorities; approaches to partnership selection, partnership organizational structures and operations; tactics to address collaboration challenges; evaluation approaches; recommendations; and lessons learned for partnership sustainability.

» Reviews of additional documents collected from hospitals and community organizations for detailed assessments of successful partnerships.

A full description of the methodology can be found in Appendix A.

This leadership guide describes a range of approaches hospitals and communities have used successfully, provides a framework for building effective partnerships and describes approaches to evaluating the effectiveness of partnerships. The guide also includes promising practices that highlight the importance of leadership, mutually understood and aligned goals, common terminology, and transparent communication—all of which will help hospitals and health systems cultivate effective partnerships and build a Culture of Health.

Building Partnerships Around Community Health Needs

Developing partnerships to address community health needs is critical for building a Culture of Health. Though the necessity for collaborative action is currently gaining traction in the health care field, many hospitals and health systems have been working with community partners for years. Leveraging existing assets in the community is an effective way to strengthen partnerships. An asset-based development plan focuses on identifying available resources within the community and building stronger relationships between all community organizations. Assets can be people, physical structures or places, community services and community organizations, which can be used to improve the quality of life within a community.[1] Though using external resources is sometimes necessary, an asset-based development plan enhances the effectiveness of internal resources and planned interventions by mobilizing the entire community's involvement through the use of local assets and skills.[2]

The partnerships described in this guide's case studies reflect the results of a 2015 survey by the Association for Community Health Improvement and American Hospital Association. This survey identified the percentage of hospitals surveyed that partnered with traditional organizations (e.g., public health departments, other health care organizations) and nontraditional organizations (e.g., educational organizations, faith-based organizations) and the degree to which they are collaborating (see Appendix A). Figure 2 lists different types of organizational partnerships identified during the interviews.

"It's [important] to think about partnerships and the process of your partnerships so that you can maximize [the] impact. We can do more collectively than we each could by totaling up our individual actions."

– Hospital leader

Figure 2: Types of Organizational Partnerships

Category	Examples
Community organizations	Social services organizations, Salvation Army, food banks, parks, zoos
Educational organizations	Early childhood centers (day care, foster care); primary, secondary and post-secondary (colleges, universities) schools
Faith-based organizations	Temples, churches, mosques, other religious or spiritual congregations
Housing and transportation services	Homeless shelters, housing and land development planning commissions, transportation authorities
Government	Local (municipal, city, county), state or federal (Dept. of Justice, Dept. of Agriculture, Dept. of Housing and Urban Development) government employees or organizations; prisons; fire and police departments; ambulance services
Local businesses	Chambers of commerce, grocery stores, restaurants, manufacturing organizations
Public health organizations	Public health departments, foundations and institutes
Service organizations	Lions, Rotary, United Way, YMCAs, Boys & Girls Clubs
Health care organizations	Other hospitals in the community, federally qualified health centers, community health centers, rural health or free clinics, mental health organizations, pharmacies, walk-in clinics, state hospital associations

Source: HRET, 2016.

CHNA-driven Partnerships

The Affordable Care Act requirement that all tax-exempt hospitals conduct a community health needs assessment (CHNA) has served as a primary catalyst for new or augmented hospital-community collaborations. A CHNA is a systematic process to identify and analyze community health needs and assets, prioritize those needs, and develop improvement strategies. Hospitals are encouraged to involve community members and stakeholder organizations throughout the assessment and implementation process. The scale at which these assessments are being done across the country makes the CHNA process a springboard for collaboration to build a Culture of Health.

In 2014, HRET examined a sample of 300 CHNAs to determine the most commonly identified community health needs.[3] The most frequently prioritized driver of community health needs was lack of access to care (67%), which includes transportation issues and provider shortages. Other commonly identified drivers include limited preventive and screening services (36%), inadequate chronic condition management (32%), socioeconomic factors (27%) and lack of insurance coverage (27%). For community needs related to health conditions, obesity (70%) and behavioral health (64%) were prioritized by about two-thirds of hospitals. Other commonly prioritized health concerns included substance abuse (44%) and diabetes (36%).

Many community health needs identified by hospitals are aligned with those identified by other community organizations, making the CHNA a prime impetus for collaboration. Hospitals and community organizations interviewed by HRET identified the same priorities as those in the 2014 sample, with many organizations focusing on increasing access to care by providing free health services, increasing provider capacity, or providing care in unique ways such as telehealth or in homeless shelters. Additionally, most hospitals and their partners focus on better preventing and managing chronic conditions and addressing socioeconomic insecurities.

"[We used] a top-down, bottom-up, grassroots type of movement in each of the outlying areas that would be sustainable. As we did this, organizations in those communities joined with us."

– Hospital leader

As the CHNA process has become more robust and new community priorities have emerged, hospitals have developed traditional partnerships as well as novel partnerships focused on needs such as behavioral health and socioeconomic issues such as food security, transportation and crime. More complex partnerships across multiple sectors are being created to address the multifaceted and interconnected nature of community needs, which will help in building a Culture of Health within the community.

Though some partnerships develop organically, a catalyst event – the initiation of a CHNA process, new policies or payment models, or emerging community health issues – often brings organizations together or revitalizes long-standing partnerships. Figure 3 outlines the process hospitals may follow to realign existing partners and identify new partners to address community needs. The timeline for developing these partnerships is dependent on a variety of factors, including the emerging health issue, availability of appropriate partners, ability to build consensus on the mission and goals, formation of trust, and available resources or expertise.

Figure 3. Hospital-Community Partnership Initiation Process

Existing hospital-community partnerships

Catalyst
• CHNA process
• New legislation/policies
• New payment models
• Emerging health issues

Identify and engage the team
• Identify new and existing partners
• Analyze data
• Conduct skill/asset mapping, identify gaps

Define each partner's roles, responsibilities and metrics
Create strategies and governance structure

Develop shared mission, vision and goals

Develop theory of change and determine strategies

Implement interventions in the community

Source: HRET, 2016.

Enhancing Existing Partnerships

Many hospitals established community partnerships before the CHNA requirement and were using these partnerships as a platform to address emerging needs in the community. These partnerships may have developed organically because the individual organizations were working on similar issues or had a shared mission that led to increased contact between them. As these partnerships mature, there is often greater integration between the hospital and its partners. Hospitals and health systems leverage these existing partnerships, which have been sustained over time, to increase impact. Such partnerships also tend to have more formal structures since the organizations have worked together on a specific project, grant or contract.

Initiating New Partnerships

When existing partners are not fully able to meet the health needs of the community, hospitals may seek out additional partners. Identifying potential partners can include a formal vetting process, which may involve examining existing resources and aligning mission and vision. Many hospitals described development of relationships with nontraditional partners, such as government or municipal agencies, faith-based organizations, and transportation and housing services, due to the uniqueness of the community need or lack of available resources.

"The point was that these people had never worked together in a collaborative [manner]. It was an opportunity for [everyone] to experience, in a structured way, how to interact with each other in ways that were productive."

– Hospital leader

Hospital and Community Organization Partnership Structures

Creating lasting positive health outcomes that lead to a Culture of Health requires sustainable partnerships that can successfully implement strategies and action plans to address community needs. Successful hospital-community partnerships exhibit:

» Effective leadership, governance and organizational structures

» Aligned mission, vision and goals

» Clearly defined roles and responsibilities

» Operational structures and processes

» Effective implementation of programs and interventions to meet community needs

» Assessment of interventions and the partnership

Effective Leadership, Governance and Organizational Structures

Developing and sustaining partnerships can be challenging, as hospitals and community organizations may have differing organizational priorities and cultures and even competing interests. It can take time to create relationships, build trust and generate consensus among partners.

Strong leadership and buy-in from the hospital board and executive team on addressing community needs — including social determinants and their impact on health — can propel organizations to action. Leaders at hospitals and at community organizations all must be committed to improving the health of the community; defining a shared mission, vision and strategic objectives; making difficult decisions; and dedicating the necessary resources for successful implementation. At some organizations, leadership is very integrated into the community, with board members or executives participating on various community boards, volunteering at community events, or acting as facilitators or ambassadors in the community on specific issues. In several interviews, hospitals and community organizations identified a dynamic, charismatic leader with vision and influence who was a key success factor for their initiatives.

Hospitals and community organizations may structure their partnerships differently depending on the need being addressed. Before beginning to develop community programs and interventions, the partners should adopt a partnership structure that enables efficient functioning based on the mission and goals of the project. These structures can range from informal ones such as ad hoc task forces and broad alliances and coalitions, to more defined structures such as steering committees and advisory boards, to formalized structures, including creation of a new backbone organization, not-for-profit company or joint venture. Many organizations discuss governance and structure at the beginning of forming the partnership so that all parties understand their roles and responsibilities.

Figure 4 shows a range of partnership structures with varying degrees of formality. Hospitals and communities have used these structures effectively to address their needs.

Figure 4. Range of Hospital-Community Partnership Structures

Informal/Loosely Affiliated

More Formalized

- Focused on networking, knowledge sharing, targeted resource, or expertise contributions
- Ad hoc committee or task force focused on specific issue or shorter-term solution

- Steering committee or advisory board with shared decision-making, resource contributions, program development and implementation
- Alliance, coalition or consortium focused on common goals

- Strategic alliance with contractual agreement (e.g. memorandums of understanding, binding contracts)

- Joint venture
- New organization such as a 501(c)(3) or separate backbone organization structure
- Dedicated operating division, subsidiary and/or staff

Source: HRET, 2016.

Communities that HRET interviewed deployed many of the models mentioned in Figure 4. While the success of the partnerships was not necessarily dependent on a formalized structure, more complex interventions that had a longer life span were organized with a more formal structure. Also, if significant funding or services were involved, a more formalized structure and agreement were often in place. Some of the interviewed communities used a more informal approach when initially deploying the interventions and later explored a more formal partnership. For smaller interventions or newer partnerships, partners used a more informal governance structure. In addition, many partnerships that shared resources in an integrated approach benefited from more structured governance to ensure mutual commitment and participation in the initiative.

Creating an advisory board "helps to really sustain the work because partners are stepping up and taking on bigger roles in areas that make sense within their spheres of influence." – Hospital leader

The most common form of governance structure is a steering committee made up of leaders from each of the key partner organizations. Many interviewees also described having less formalized or ad hoc partnerships that support the steering committee's key initiatives, or using workgroups or subcommittees to focus on specific topics or initiatives.

Members of steering committees and advisory boards working to build a Culture of Health often include leaders

from each of the partner organizations for strategy development and key decision-making, as well as staff members responsible for day-to-day operations and implementation. Doing so can balance substantive and procedural tasks, and also integrate diverse skills and perspectives to make progress toward building a Culture of Health.

Most hospitals and community organizations have a core group of community partners that are closely aligned within their coalitions and alliances. More formally organized, this core group of partners focuses on strategic planning, has designated leadership and resources, and exhibits a high degree of mission and goal alignment. Most hospitals also have a broader set of other community partners, typically working together with a less formal arrangement or created for specific target issues. Many of these core partner groups and other community partners have formed workgroups and subcommittees and successfully addressed prioritized community needs as well as operational needs. (See Figure 5.) Staff from both partner groups may participate in workgroups or subcommittees more focused on implementation and day-to-day operations.

Figure 5. Operationalizing Hospital-Community Partnerships
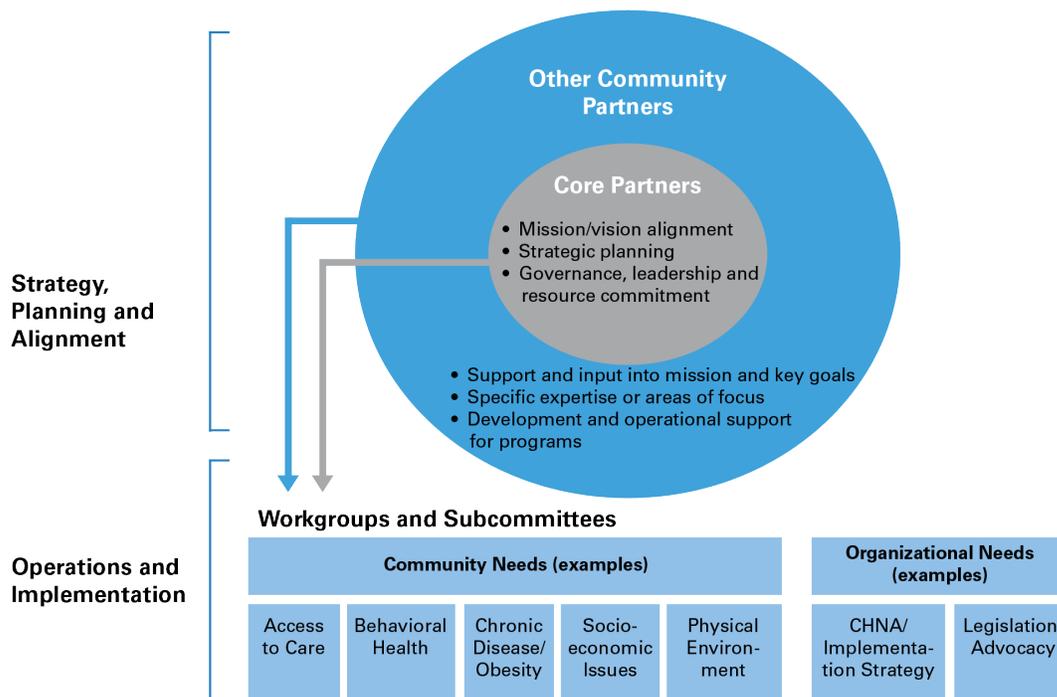
Source: HRET, 2016.

Aligned Mission, Vision and Goals

Ultimately, multisectoral partnerships should have a shared mission, vision, goals and strategic objectives to inform the development of joint initiatives, metrics and timelines for achievement.

Several partnerships interviewed by HRET use Mobilizing for Action through Planning and Partnerships (MAPP). Using this community-driven strategic planning process, communities prioritize health issues in a collaborative manner. MAPP assists partnerships as they move through six phases: organizing for success; visioning; assessments; identifying strategic

issues; formulating goals and strategies; and implementing an action cycle. More information about the MAPP process is available at http://archived.naccho.org/topics/infrastructure/mapp/.

Interviewees also stressed that, early in development of the partnership, it is essential to work through any erroneous assumptions and build trust through transparent, candid communication. Almost all of the partnerships interviewed hold regularly scheduled meetings and touch points. These meetings can be collaborative, informative and/or decision oriented.

Defining strategic goals and objectives is essential when building an effective partnership. Partners should develop goals and objectives together. By incorporating defined goals for their shared initiatives and overall partnership, partners can deliver the best of their resources and leadership strategies. The mission, vision and goals should focus on clearly defined, high-priority needs of the community. Goals can be audacious; it can be more inspiring to the community to be working toward big goals than aiming for process-level goals. The partnership's goals should be clearly stated, widely communicated and fully supported by all partners.[4] Working toward commonly accepted and understood goals provides focus and orientation for partnerships.[5] Goals may change over time, and the partnership can benefit from continuing to monitor community health needs and then shift focus, depending on changing needs and available resources.

Clearly Defined Roles and Responsibilities

Clear expectations and roles are essential to a successful partnership. If each partner is making a meaningful contribution – not just participating in meetings, but truly engaged and driving the efforts forward – the initiatives are more likely to have positive outcomes. The various types of roles that hospitals and community partners can play are detailed in Appendix C.

Hospitals and their partners provide resources, skills and expertise that are beneficial for a successful collaboration. According to interviewees, partners can contribute a wide range of resources and roles, including:

» Funding

» Facility space and utilities

» Expanded staff and volunteers

» Data sharing and analytics

» Increased access to care (e.g., diagnostic vouchers, clinic hours)

» Grant-writing assistance

» IT and technical support

Interviewees stressed that partners should make meaningful contributions – not just funding the effort or providing their reputation, but really driving the efforts forward. Partners should not simply sign an agreement or attend a meeting. They must be actively engaged, know what is happening in the community and in the partnership, and take an active role in decision-making and implementation.

For many of the partnerships, the roles and responsibilities were defined at the beginning, before deploying any interventions. To avoid duplicating efforts, effective partnerships spend time upfront identifying the appropriate operational models and roles for their initiatives. Several of the hospitals interviewed used some type of worksheet to determine the capacity of the other partners as they developed operational structure, roles and contributions. Some hospitals discussed the need to meet in person with partners early in the process to talk through concerns and understand any barriers. In general, community partners found it easier to work with hospitals that had dedicated staff for community engagement.

Operational Structures and Processes

Integrating efficient structures, processes, communications and documentation into a well-constructed partnership leads to more optimal functioning. If the partnership adapts formal written agreements and charters to document mutual mission and vision statements, financial plans, action plans, and roles and responsibilities of each participant, the collaboration can advance efficiently and effectively. Several communities that were interviewed described using contracts, memorandums of understanding, or signed letters of agreement that were developed by the partners to formalize their roles and structure.

Less formal documentation was used by some communities to describe the scope of work, end goals, evaluation approach, roles and more. Such documentation includes convening documents, pledges, rules of engagement or confidentiality agreements. For example, one organization developed a "Ten Commandments" document for how to work together. Only a small number of the partnerships created a formalized bylaws system for operations and processes. Partnerships that developed bylaws were considerably large, had more formal structures or focused on several different interventions.

For meetings of governing boards or steering committees, the focus may be more strategic, while workgroups and subcommittees may focus more on action plans, tasks to be accomplished and operational decisions. Some of the successful partnerships reiterated their goals at every meeting, while others recommended reviewing objectives regularly and adapting as needed. Developing an orientation document or process is also helpful for bringing new partners on board, but ongoing education and communication are needed for partners as well. Detailed meeting minutes, documentation of decisions and strategies, and ongoing communication help maintain relationships and keep all community partners engaged and aware. Several interviewees stressed the need for meetings to be collaborative and informative. Some organizations have developed websites, newsletters or regular email distributions for their partnerships to document and communicate the progress on initiatives.

Programs and Interventions to Address Community Needs

The community partnerships that were interviewed had created a variety of interventions and programs to address a multitude of health determinants. Many of the interventions and programs deployed by the partnerships were evidence-based programs. Several partnerships used existing programs and "tweaked" the programs to fit a new and emerging health issue or different populations.

Based on the interviews, many community partnerships are addressing four key health areas: healthy behaviors, access to care, economic and environmental development, and behavioral health and substance use disorders. Figure 6 provides a sample of different programs that were highlighted during the interviews.

Figure 6. Sample of Hospital-Community Intervention Programs

Program Category	Examples
Healthy Behaviors (for chronic health issues or prevention) *Nutrition and healthy eating:* community gardens, cooking classes, recipes, health fairs, food banks and grocery stores with healthy foods *Active living:* weight loss, exercise programs, recreational activities *Prevention and wellness:* child safety, immunizations, screenings, prenatal support	**Ochsner Medical Center** in Louisiana partnered with a local Baptist church congregation to develop activities and bring health education into the community, tailored to congregants' needs and interests. The ultimate goal of this partnership is to help the congregation live healthier, happier and longer lives. **Paris Community Hospital** in Illinois formed the Bee Well of Edgar County, a community wellness coalition. This coalition is in its first year of providing educational vegetable gardens to teach residents about gardening and healthy food choices.
Access to Care *Coverage:* rates for uninsured and underinsured, access to insurance programs (e.g., Medicaid, Children's Health Insurance Program), affordability of insurance, affordability of care, free health services *Increased capacity:* community health workers, AmeriCorps volunteers, job training for students *Care in new settings:* telehealth, health care provided in home-less shelters, mobile health and dental units, school-based clinics *Care and insurance navigation:* insurance sign-ups, care coordination	**Montefiore Health System** in New York co-created #Not62—The Campaign for a Healthy Bronx, which brings together organizations and individuals to work collaboratively to improve the health of the Bronx, by pledging to live, work and play in a manner that improves the overall health of Bronx County. The #Not62 campaign is supporting access to primary care and preventive services by working with the New York Health Department to open new community health clinics that will significantly expand primary care services. The campaign also is opening a Neighborhood Health Action Center in the Bronx to provide space for primary care and holistic nonclinical services.

Program Category	Examples
Access to Care (*continued*)	**Piedmont Healthcare** in Atlanta has prioritized the need to increase access to affordable and appropriate care for all community members regardless of race, gender, insurance status, income level, etc. To decrease overuse of local hospitals' emergency departments and improve patient health outcomes, Piedmont Healthcare partnered with the community to create the Sams Care Coordination Program, which has expanded the capacity at charity clinics. Through the Sams Care Coordination Program, Piedmont offers lab and other diagnostic services free of charge to charitable clinics, providing care across the continuum for those most in need, as well as access to their electronic medical records.
Economic and Environmental Development *Housing:* access, affordability and safety of housing options (e.g., lead poisoning, mold), housing stability, home rehab and purchase *Transportation:* availability, distance and time needed to reach appropriate facility *Safe environment:* air and water quality, neighborhood recovery and restoration, safe streets, park development and school renovations, emergency planning, violence deescalation *Economic security:* workforce development, youth jobs, training and mentoring, poverty awareness training	**Southwestern Vermont Medical Center** has worked with the local government on projects such as the building of biking and walking paths. One such project is a path and boardwalk that will connect two affordable housing complexes, so that residents can safely walk to schools, jobs and grocery stores. **Montrose Memorial Hospital** in Colorado works with the local school district, providing opportunities for high school students to be mentored and do job shadowing within the health field. This program is designed to expose high school students to potential health care careers.

Program Category	Examples
Behavioral Health and Substance Use Disorders *Behavioral health and substance use disorder treatment programs and policies:* includes issues related to depression, personality disorders, ADHD, anxiety-related mental disorders, emotional stability, schizophrenia, eating disorders, suicide, prescription and illicit drugs (e.g., heroin, meth, cocaine), opioid abuse *Providing integrated care within the community:* increased availability and accessibility of services and providers to address needs related to behavioral health and substance abuse, mental health first aid, crisis training, workforce development	**Intermountain Healthcare**, based in Utah, created an opioid abuse awareness program called "Save Lives, Not Medication," which educates patients to throw away old medications. **Olympic Medical Center** in Washington state works with a local community mental health agency to address medical health needs for its populations. Together, the organizations identified a need for a crisis center in the community and created a six-bed facility where people with mental health needs can go for treatment before there is a need for in-patient psychiatric assistance. **Neosho Memorial Regional Medical Center** in Kansas worked closely with South East Kansas Mental Health Center on care coordination and transitional care services for people with mental illnesses and expanded services to its home health organization. The medical center observed a reduction in inappropriate emergency room usage and hospital admissions.

Source: HRET, 2016.

Assessment of Interventions and the Partnership

Creating effective partnerships in the community requires evaluating the interventions and partnership itself. In general, the partnerships interviewed by HRET evaluate their effectiveness based on the results of their interventions, either through process or outcome measures, and the functionality of the partnership itself. Though most interviewees evaluate their programs, only a few partnerships currently evaluate the partnership itself and how well they work together. RWJF has developed [metrics to align with its Action Framework for building a Culture of Health](). These big-picture metrics help communities evaluate where they are positioned based on various drivers, which may stimulate ideas for areas that could be pursued to further their Culture of Health efforts.

Every partner should have input into the creation of the partnership's metrics. Metrics should be agreed upon at the outset of the partnership and should be measurable, focused, simple and clear to their purpose and measurement. Tracking the partnership metrics is often done using a dashboard or scorecard. Metrics tracking and reporting should be regularly sent to partners. Other considerations for partnership metrics include:

» Evaluating the cost/benefit and the return on investment of the interventions and programs across the entire health system and community

» Integrating grant funder requirements into the final metrics and ensuring proper alignment between the grant and partnership's metrics

» Linking different data sources and including patient data whenever possible in the metrics; also may include creating a shared electronic medical record so all partners have access to the same data

» For hospitals serving the same market, using public data to avoid duplicating efforts of community members and partners

Assessing the community partnership allows partners to identify gaps in their operations and deployment. A periodic "check-in" on the health of the partnership may be a useful approach to continuously thinking about improving the quality of the partnership itself. Applying a Plan-Do-Study-Act model will help facilitate rapid cycle improvement and ensure that the partnership quality is being considered – what works and what doesn't work – and improved throughout the lifespan of the partnership. Additionally, as new partnerships form, partners can use the lessons learned from failed and less effective partnerships to build more successful collaborations.

Partnerships can measure the effectiveness of their interventions through process and outcome measures (see Figure 7). Beyond interventions, it is also vital to measure the effectiveness of the partnership itself (see Figure 8).

Metric Measurement Areas	Examples
Process measures: focused on program participation or reach	» Number of screenings provided » Number of participants » Participant satisfaction » Number of patient visits » Use of educational website » Event attendance

Outcomes measures: focused on specific health results related to program intervention or impact on community needs and population health status	» Institute of Medicine's "Vital Signs: Core Metrics for Health and Health Care Progress"[6]:
	  » Health status metrics
	    » Life expectancy at birth
	    » Self-reported health
	    » Body mass index (BMI)
	  » Social determinants metrics
	    » High school graduation rate
	    » Health literacy rate
	    » Social support
	  » Health care-related metrics
	    » Health care-associated infection (HAI) rate
	    » Preventable hospitalization rate
	    » Patient–clinician communication satisfaction
	» County Health Rankings & Roadmaps[7]
	  » Health behaviors (e.g., smoking, physical inactivity, excessive drinking, access to healthy foods)
	  » Clinical care (e.g., percentage uninsured, access to primary care physicians, dentists and mental health providers)
	  » Social and economic factors (e.g., unemployment rates, children in poverty, income inequality, violent crime)
	  » Physical environment (e.g., air pollution, housing problems)
	» Healthy People 2020 objectives[8]

Metric Measurement Areas	Examples
Outcomes measures (*continued*)	» Other health or social determinant outcomes 　» Quality of life indicators 　» Economic status (e.g. unemployment rates, percentage below poverty) 　» Pre- and post-test health results 　» Academic achievement and attendance results 　» Changes in behavior, attitudes or knowledge 　» Community engagement 　» Cost avoidance 　» Health status 　» Social benefits

Source: HRET, 2016.

Only a few of the partnerships interviewed conduct an evaluation of the partnership itself and how well the partners are working together to achieve their goals. Figure 8 includes examples of the types of metrics to use, including the degree of partner engagement, teamwork effectiveness and community responsiveness.

Figure 8. Metrics for Assessing Partnership Effectiveness

Metric	Examples
Partner engagement	» Number of partners attending meetings » Percentage of partners actively participating in activities or interventions » Number of meetings or communication touch points » Increase in the number of connections between community organizations (network analysis) » Level of engagement within the partnership » Partner satisfaction with its own level of engagement » Partner satisfaction with its own role in partnership
Teamwork	» Perceived team effectiveness in general and on specific issues » Ability to identify and address weaknesses as a team » Identified barriers to effectiveness » Assessment of what the partnership is lacking to truly be effective » Ongoing qualitative and informal feedback from team members
Community responsiveness	» Inclusive and representative of community being served » Identification and action on issues that matter to people » Community perception of partnership efforts » Availability of opportunities for community members to participate in activities

Source: HRET, 2016.

Some partnerships use a modified Results Based Accountability process — a data-driven process that focuses on the end goal and has the partners work backward — to determine metrics to address these questions: "How much is the partnership doing?" "How well did the partnership do it?" "Who benefited from the partnership?" Other partnerships use the collective impact measurement model — partners design, develop and deploy— to assess and evaluate the partnership's effectiveness.

Hospitals and community organizations interviewed utilized a range of surveys and resources to measure the effectiveness of their partnerships. These include:

» **Community Organizing and Community Building for Health and Welfare**. Edited by Meredith Minkler, this book discusses cultural relevance and humility, and includes case studies in areas ranging from childhood obesity to immigrant worker rights to health care reform. The book's appendices include guidelines for assessing coalition effectiveness and training tools such as "policy bingo."

» **Wilder Collaboration Factors Inventory**. This tool was created by the Amherst H. Wilder Foundation and provides an assessment of collaborations, based on 20 research-tested success factors. The factors include history of collaboration in the community; social and political climate; mutual respect; understanding and trust; appropriate cross-section of members; ability to compromise; shared stake in outcomes; layers of participation; clear roles and guidelines; communication; and shared vision and purpose. The inventory takes about 15 minutes to complete and can be distributed to a small group of leaders in a collaborative, during a general meeting, or via mail to all members for the most complete picture.

» **The Health Impact Collaborative of Cook County Survey**. This partnership is between the Illinois Public Health Institute, hospitals, health departments and community organizations across the city of Chicago and Cook County, Illinois. The partners conduct a joint CHNA, as well as action planning and implementation activities across three regions in Cook County. As part of an external evaluation funded by the Robert Wood Johnson Foundation, collaborative partners participate in a survey on their backgrounds and perceptions about the collaborative's activities to date. See Appendix D.

» **The Duke Division of Community Health** created a partnership evaluation survey to learn about their partners' satisfaction with and impact of the partnership. This survey consists of Likert scale and open-ended questions. See Appendix E.

» **Coalition Member Assessment**. Created by Tom Wolff and Gillian Kaye, this assessment is a variation of earlier satisfaction surveys. Members rate their coalition on a 1 to 5 scale, from "agree" to "strongly disagree," answering 44 rated questions and several open-ended questions. Questions cover preferred level of involvement, partnership vision, leadership and membership, structure, communication, activities, outcomes, relationships, personal and organizational benefit from participating, and areas for improvement. Appendix F provides more detail on the self-assessment survey questions.

Overcoming Obstacles in Partnership Development

Hospital-community partnerships face several common barriers and challenges. These barriers and challenges influence the effectiveness and sustainability of the partnership's interventions. Figure 9 details the most commonly identified challenges as well as potential solutions to address these challenges.

Figure 9. Key Challenges in Hospital-Community Partnerships and Potential Solutions

Challenge	Possible Solutions and Success Factors
Leadership and Organizational Alignment	

» Competing organizational priorities and timelines between partners
 	
» Getting the right people to the table at the right time
 	
» Limited awareness among leadership of community needs and potential partnership opportunities
 	
» Length of time to build trust and relationships
 	
» Limited number of organizations with whom to partner, particularly in rural areas
	» Leadership buy-in
	
	   » Identify dynamic leaders to represent the partnership
	
	   » Ensure leaders from each partner organization are involved with making decisions and that the right staff are included for implementation
	
	   » Continually educate and communicate to leaders on the mission, goals and progress
	
	   » Find champions from a variety of settings to demonstrate widespread interest and commitment
	
	» Alignment with each organization's mission
	
	   » Choose to address issues that key stakeholders in the community care about and relate to each organization's mission and/or identified needs
	
	   » Identify and engage organizations that share a common mission, vision and goals related to community needs

Organizational Culture	

» Partners not always "speaking the same language" on the same issues
 	
» Different cultures and approaches to solving the same problem
 	
» Social determinants being addressed in silos
 	
» Organizations accustomed to taking the lead or prefer certain approaches
	» Ongoing dialogue
	
	   » Create a common language and definitions for discussing approach
	
	   » Regular reflection to focus on the shared mission, vision and goals
	
	   » Focus on being transparent, candid and respectful
	
	   » Provide a safe, respectful forum to discuss barriers and mechanisms to resolve conflicts
	
	   » Build upon past partnership history to promote trust and communication
	
	» Organizational structure
	
	   » Utilize a neutral, objective organization to be the backbone

Challenge	Possible Solutions and Success Factors
Partnership Structure and Operational Resources	

» Lack of clear structure for who supports or "hosts" partnership, roles of partners, etc.
 	
» Certain types of partners may be underrepresented (e.g., payers, local businesses)
 	
» Limited staffing or other resources with competing demands
	» Clarify, define and document roles and responsibilities of each partner
	
	   » Identify advisory roles for leadership from partnership organizations and roles for implementation staff
	
	   » Have key people or a department dedicated to supporting the partnership
	
	   » Set up agreed-upon communication pathways, deliverables and timelines
	
	   » Create formal structure and/or collaborative agreement between partners that permits flexibility and adaptability as the partnership develops
	
	» Utilize existing talent and identify gaps in expertise
	
	   » Include key hospital and community organization leaders in partnership meetings and decisions
	
	   » Identify and plan around community assets to pool potential resources together

Sustainable Funding Sources	

» Limited long-term funding sources – existing grants focus on specific projects, not long-term partnerships or operations
 	
» Lack of alignment between health care financial payment models and population health
	» Leverage existing assets, resources and people in the community (volunteers, existing space)
	
	   » Bring nontraditional partners into the partnership, such as churches, school districts and law enforcement
	
	   » Build coalitions with other similar initiatives to pool resources
	
	   » Dedicate a portion of funding from operating budgets of hospitals and partners
	
	   » Leverage hospital foundation or philanthropy dollars to align with work
	
	» Identify external funding sources
	
	   » Dedicate staff to finding external funding sources, such as grants from both governmental and nongovernmental entities
	
	   » Identify event sponsors to underwrite costs
	
	   » Pursue value-based payment models that align with population health management

Challenge	Possible Solutions and Success Factors
Program Implementation	
» Moving from assessment to strategy to action, given other organization needs and limited resource capacity » Maintaining momentum and engagement once the project is launched	» Develop a strategy with clearly defined tasks, roles, responsibilities and timeline for individuals from each partner organization » Assign a "taskmaster" to keep tasks on track and document on a shared dashboard » Demonstrate early successes (process and preliminary outcomes metrics) from pilot projects to demonstrate potential » Engage progressive organizations/early adopters to partner on new strategies (more entrepreneurial) and enable them to become champions; spread successful pilots more broadly
Measurement and Evaluation	

» Availability of data and ability to share (e.g., using different electronic health records or data sources)
 	
» Defining clear and meaningful metrics
 	
» Evaluating and monitoring results, including meeting different reporting requirements for each partner organization
 	
» Ability to document positive return on investment
	» Determine data-sharing strategy
	
	   » Agree on what data should be shared between partners
	
	   » Explore possible alternative avenues for data sharing such as the creation of a new electronic medical record
	
	   » Explore metrics where all partners have access
	
	   » Develop a health information exchange mechanism
	
	» Get each partner's input on metrics
	
	   » Keep metrics simple and focused on goals/outcomes
	
	   » Regularly report results to all partners on progress and outcomes
	
	   » Consider using a Plan-Do-Study-Act (PDSA) approach to make adjustments quickly
	
	   » Evaluate cost, benefit, and return on investment, especially at the community level
	
	   » Flag high utilizers in data collection systems wherever they are seen and monitor specific progress on those "familiar faces"

Source: HRET, 2016.

Creating an Effective and Sustainable Partnership

Creating an effective and sustainable hospital-community partnership requires effective organization, alignment of all partners, and a shared mission and vision. Hospitals and community organizations can benefit from a structured system that addresses each partner's needs and the partnership's goals. For additional strategic considerations on building a Culture of Health, see the 2014 HRET report "Hospital-based Strategies for Creating a Culture of Health."

The strategic considerations in Figure 10 provide an overview of the areas needed to create an effective and sustainable partnership.

Figure 10: Strategic Considerations for Creating an Effective and Sustainable Hospital-Community Partnership

Partnership Leadership and Governance
Develop an informal or formal governance/steering group (e.g., coalition, board, committee) comprised of individuals representing each partner organization.
Obtain support and commitment from partners' CEO, senior management team, board of trustees and other key leaders.
Develop succession plans with current and future leaders so that partnership does not entirely rely on one person or organization.
Have all partners agree on the mission, vision, goals, objectives, and appropriate intervention strategy.
Draft any legal agreements or memorandums of understanding to solidify the partnership structure, as needed.
Present return on investment case to each organization's leadership.
Partnership Structure and Culture
Clearly define roles and responsibilities of each partner.
Convene active workgroups and committees that focus on execution and continually work to address challenges and barriers.
Engage partners in collaborative problem-solving of jointly shared problems.
Discuss lessons learned on an ongoing basis in order to modify and strengthen partnership structure and processes.
Ensure transparent and frequent communication between partners and other key stakeholders.
Regularly conduct informal reviews (e.g., Plan-Do-Study-Act cycle) of partnership quality to identify any areas for improvement.

Partnership Program Development and Implementation
Identify health needs through a community assessment, with participation or input from key partners. Develop programs based on prioritized community health needs.
Ensure partners agree on the scope of the interventions (e.g., focus on a few targeted conditions/drivers or a comprehensive range of health and sociological issues).
Identify any evidence-based interventions and promising practices for the identified need, and agree upon process and outcome metrics.
Identify community assets to determine all available resources (e.g., financial, time, facility space, staff, IT, in-kind or other resources) and potential partners.
Identify and apply for secure, sustainable funding. Consider pilot grants if long-term funding is unavailable.
Tracking Partnership Outcomes
Adopt an existing partnership assessment survey tool to periodically gauge partnership satisfaction.
Measure the impact of the partnership's efforts on the stated goal. Select process measures to signal progress toward the long-term goal.
Share data among partners, particularly as they pertain to partnership goals.
Share data with community stakeholders and community members to demonstrate progress.
Ensure that partners measure the perceived quality and impact of the partnership to impact health.
Evaluate partnership's impact on how it may facilitate ongoing community relationship within and outside the partnership.
Celebrate successes and communicate stories broadly.

Source: HRET, 2016.

Conclusion

Hospitals and community stakeholders are increasingly recognizing the value of developing effective partnerships to improve the health of their communities and build a Culture of Health. Hospital-community partnerships can create a greater impact by aligning resources, knowledge, skills and expertise. Partnering to address community health needs does not always come naturally. Community partnerships have to be structured and fostered to promote open communication and joint action around shared interests and community needs.

HRET's interviews with leaders at 25 hospital-community partnerships demonstrate that such partnerships are possible – and can have a great impact on the health of the community – when done properly. To build an effective, sustainable partnership of hospitals, health systems and community organizations working collaboratively toward building a Culture of Health, the partners must intentionally identify and engage key stakeholders, reach a consensus on the community health priorities they will address, set up a sustainable infrastructure, and secure long-term funding sources. Even with all of these pieces in place, trust and communication between community partners – and a shared dedication to a joint mission – are essential to building a Culture of Health.

SouthEast Alaska Regional Health Consortium

Juneau, Alaska

Background and Partnership Structure

The SouthEast Alaska Regional Health Consortium (SEARHC) is a nonprofit tribal health consortium with Alaskan native people working in partnership to provide the best health care for their communities.

SEARHC offers services to 18 native communities in Southeast Alaska, including Tlingit, Haida and Tsimshian villages. Established in 1975, SEARHC has since expanded and developed stronger relationships with the tribal communities. Ensuring community involvement and input, representatives from 15 of these communities form the executive board. SEARHC also created a web tool that allows community members to share their past health experiences, motivating others to seek healthier lifestyle choices. SEARHC operates Mt. Edgecumbe Hospital in Sitka, providing acute, critical, obstetrical, surgical and perioperative care in a 25-bed facility.

An advisory board of 15 members, each from a different tribe, assesses the needs of the community. SEARHC collaborates with medical providers to get input on the most common health issues affecting incoming patients. Through the Mobilizing for Action through Planning and Partnership (MAPP) process, a community-driven strategic planning tool, SEARHC identified high obesity rates, substance abuse, and lack of affordable and accessible traditional and local foods as major health concerns in the Sitka community.

Tribal councils within the communities also provide additional grants to address health care issues surrounding residents, including alcoholism and opioid use. SEARHC identified the need for jobs, housing and a support network or mechanism, such as family and friends, to guide addicts away from substance and alcohol abuse by reaching out to local community members. SEARHC is expanding its outreach capacity by conducting a behavioral health risk factor surveillance survey every two to three years, and partnering with local government and schools for local food and physical activity assessments. Because of high suicide rates in Alaska, SEARHC identified local suicide prevention coalitions and entities to create additional interventions focused on strengthening family resilience and culture.

Community Programs

SEARHC developed community partnerships to promote healthy lifestyle choices for Alaskan residents, including:

» The Sitka Health Summit. Encourages and empowers community members to identify their health needs and challenges. Based on the community's input, the summit develops initiatives to address those needs effectively. Successful interventions have emerged through this organization, such as Fish to Schools and the Alaska Bicycle and Pedestrian Alliance. Fish to Schools is a partnership between schools, fishermen, food service and seafood processors to create a school lunch program that offers locally caught fish. Third graders receive Stream to Plate lessons. The community hears media stories about Fish to Schools throughout the year. A free resource guide and lesson plans are available for schools interested in developing their own Fish to Schools program.

» Association for the Education of Young Children (AEYC). This program works to implement health and nutritional education among schools and community centers, which affect students, teachers and parents. The Growing Greens program derived from AEYC has promoted the advantages of locally grown produce and increased the amount of children consuming fresh greens in Southeast Alaska.

» Jilkaat Kwaan Heritage Center (JKHC). This nonprofit organization focuses on organizing programs through the Heritage Center's traditional knowledge camp and community garden program, which include opportunities to increase accessibility and availability for good nutrition via traditional subsistence foods and locally grown produce. The JKHC programs provide opportunities for physical activity, cultural education, as well as employment based on cultural tourism. The organization enhances environmental, social and economic stability through their holistic approach.

Results

Through collaboration, the Fish to Schools program provided locally caught fish in school lunches to fulfill the American Heart Association's recommendation of consuming at least two servings of fish per week. In 2014, about 1,825 students were positively influenced by this movement, compared to zero in 2010. Because of continued efforts from the Alaska Bicycle and Pedestrian Alliance, Sitka is nationally recognized as a walk-and-bike-friendly community. The Growing Greens program also increased exposure to growing and preparing fresh produce, and an additional 27 percent of Alaskan children now have access to produce as well. Cultural programs and camps formed by the JKHC have empowered young participants to become positive role models in the community.

Lessons Learned

SEARHC adapted certain processes to create effective and sustainable partnerships. Examples are:

» SEARHC developed a memorandum of understanding with the JKHC and other partnering organizations to specify roles and responsibilities.

» Outreach for suicide prevention interventions were maximized by involving the local police and emergency departments.

» Experts on food and nutrition worked with elders from the tribal community to better understand the history and benefits of local foods, encouraging communication between community members and organizations.

» Developing interventions with already established partnerships utilizes the best available resources and expertise.

» Follow-ups were administered by primary care physicians at the hospital to evaluate the effectiveness of health care practices.

» Client satisfaction surveys were used to measure effectiveness of partnerships for all grant-funded projects and behavioral health clients.

SEARHC aims to further strengthen its partnerships with community organizations to promote healthy living choices and create a positive impact in the community.

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Indiana University Health

Indianapolis, Indiana

Background and Partnership Structure

Indiana University Health (IU Health), is a large health care system with 17 locations around the state of Indiana, providing primary care and specialty services. IU Health is involved in breakthrough research of treatments and services through its partnership with the Indiana University School of Medicine. As a mission-driven organization, IU Health is committed to improving the health of communities it serves. In 2012, IU Health partnered with many community organizations and businesses to address their community health needs through the development of a community health needs assessment (CHNA). CHNAs conducted by each one of the 18 locations collectively identified access to affordable health care, obesity prevention, behavioral health and pre-K–12 education as priority health concerns in the community.

During the 2015 CHNA cycle, IU Health worked with other Indiana hospitals to conduct its CHNAs and built strong partnerships with health systems and community organizations through the process. This partnership required regular communication between IU Health and other health systems, as it allowed them to share primary and secondary data and resources. IU Health invited organizations with specialized expertise to implement programs to reduce health concerns such as poverty and low literacy. A memorandum of understanding was used with each partnership to establish mutual understanding of expectations, roles and responsibilities related to deliverables, measurable outcomes and evaluate productivity.

Community Programs

The community in Indiana is positively affected through many programs supported by IU Health. Some of these are:

» Gleaners Food Bank of Indiana. As a large food bank in Indiana, Gleaners serves 21 counties with a large geographical reach, ranging from urban to rural populations in Indianapolis. In 2015, IU Health funded the CARE Mobile Pantry, which offers 6,000 meals per week to six target neighborhoods affected by high rates of poverty, food insecurity, unemployment and violent crime. The program seeks to reduce crime rates in communities by deescalating tension caused by hunger. Food distributions are conducted by volunteers from staff, as well as local police and public safety departments, to build goodwill among residents.

» Strong Schools. IU Health provided grants, additional staff and health experts to elementary schools to improve student health and academic achievements, by incorporating physical activity into the school day. IU Health provided schools $1,500 to $3,000 to add before- or after-school programming, Action Based Learning, or enhance physical education curriculum or recess. Schools were required to submit midterm and final evaluation reports of average daily physical activity of students to determine the effectiveness of the program. In the 2014–2015 school year, the program was integrated by 23 elementary schools from 14 school districts across 8 counties, reaching 9,626 students.

» Kindergarten Countdown. In 2011, IU Health began a five-year partnership with the Indiana Association of the United Way of Central Indiana to replicate and expand the Kindergarten Countdown program focused on improving literacy rates of at-risk kindergarten students. Besides financial support, IU Health provided the program with in-kind resources such as books, classroom supplies, backpacks, t-shirts, printing, volunteers and marketing materials. Because 40 percent of Indiana children enter kindergarten lagging in emotional, social and intellectual skills, the program started the Kindergarten Countdown camp to reinforce skills required to be successful in school. By 2015, more than 20 camps were available in 12 counties, reaching nearly 1,700 kids over the five-period.

Results

Gleaners Food Bank of Indiana provided 450,120 pounds of food to six neighborhoods in three months. Food distributions served an average of 200 households, exceeding the original goal of 120 households. Gleaners also educated residents about the benefits of healthy eating by distributing 2,200 educational materials on nutrition. Through a survey, 93 percent of clients reported feeling extremely satisfied about their experience with the CARE Mobile Pantry while 79 percent felt the program significantly improved their food security. The program plans to establish relationships with the neighborhoods by encouraging more involvement by volunteers and city representatives. In addition, the partners saw a drop in crime rates within the target communities.

Ninety-five percent of participating IU Health Strong Schools increased students' average amount of physical activity by 52 percent, from 34 minutes to 52 minutes. This allowed students to receive 87 percent of the daily recommendation of 60 minutes of physical activity. In one year, IU Health Strong Schools added 27,725,760 new minutes of physical activity to the school year. Strong Schools continues to survey participating schools to determine its effectiveness.

Annually, more than 400 students participated in the Kindergarten Countdown camps, reaching nearly 1,700 children over a five-year period. One student in the lowest 25 percent of his peers for academics is now one of the top readers in his class. Surveys conducted by the program showed that 99 percent of parents felt their child was better prepared for kindergarten, which was supported by a 21 percent improvement in Get Ready to Read preliteracy scores of participating children across 22 counties. Parents, teachers and camp coordinators noticed more confidence and excitement in children after camp as 90 percent of participants exhibited gains in kindergarten readiness skills.

Lessons Learned

» A memorandum of understanding with partners to define roles, expectations, goals and accountabilities is important in building strong partnerships and successful outcomes.

» Frequent meetings and communication with partners and steering committees help establish equal understanding of the ultimate goal for each project and can help bring the group to a common path.

» IU Health built sustaining relationships with existing partners by involving their expertise, staff and resources in future interventions.

  » Staff from the Indy Hunger Network, a coalition of multiple food service providers, contribute their knowledge and skills of running food banks to the Gleaners Food Bank of Indiana.

» Assessment tools such as client satisfaction surveys, outcome metrics and reports should be used to help guide the evaluation process.

IU Health is continuously working toward identifying health issues and disparities in both urban and rural communities. It also is developing ways to incorporate new innovations and existing best practices, and resources such as health systems, community centers and nonprofit organizations to positively influence the community.

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PIH Health

Whittier, California

Background and Partnership Structure

PIH Health is a fully integrated health care delivery network that serves more than 2.1 million residents in Los Angeles and Orange counties, as well as the San Gabriel Valley region in Southern California. The PIH Health network is comprised of two hospitals: PIH Health Hospital-Whittier and PIH Health Hospital-Downey, and features multiple outpatient medical offices, a multispecialty medical group; home health and hospice care; and comprehensive programs in heart, cancer, stroke, women's health, rehabilitation, palliative care and emergency services.

West Whittier-Los Nietos, located in southeast unincorporated Los Angeles County, has a population of approximately 25,500 people, of whom 88 percent are Latino. More than 30 percent of children in the West Whittier-Los Nietos community are obese, significantly higher than the national Healthy People 2020 childhood obesity target of 14.5 percent. In addition, the West Whittier-Los Nietos community was ranked among the highest in all of Los Angeles County for obesity prevalence. The Los Nietos School District serves more than 1,700 children in this area, with three elementary schools and one middle school.

In 2011, recognizing the rising rates of childhood obesity as well as fewer district resources to provide physical and nutrition education, the Los Nietos School District and PIH Health formed Healthy Los Nietos (HLN), a school-based wellness collaborative. The strength of the collaboration between PIH Health and the Los Nietos School District is that two distinct entities with their own terminology, culture and hierarchy learned to work together effectively and form a cohesive partnership. This relationship has grown into a thriving community collaborative comprised of additional partners that include the city of Santa Fe Springs, the Los Angeles County Department of Public Health, THINK Together after-school programs, Activate Whittier collaborative, AltaMed, Dairy Council of California, and the Community Resource Center (LA County Board of Supervisors). The HLN collaborative is focused on increasing the number of students who maintain a healthy weight and strives to improve the overall health and wellness of district staff and families. Core HLN components include coordinated student education on health and wellness topics; annual student health screenings and immunizations; school wellness policy and environmental change strategies; and parent and community engagement.

An HLN Community Advisory Board (CAB) was established in 2013, and organizational stakeholders developed a formalized vision, mission, strategies, measurable objectives and a team structure to carry out the work. The HLN-CAB sustains the work of the collaborative, as it defines the roles and responsibilities of each partner. It also identifies needs and evaluates the success of interventions, increases awareness among the Los Nietos community and secures additional grant funding. Recognizing the importance

of sustainability, each of the partner agencies invests internal resources so that HLN is not completely dependent on grant funding to carry out its initiatives, allowing each member to expand its target audience reach and exposure to programs and services.

Community Programs

The HLN collaborative has implemented interventions, infrastructure and policy changes to sustain school-based wellness in the Los Nietos School District. These include:

» Revamped School Nutrition Services. The school district now offers diverse, healthy food options, including cafeteria salad bars and breakfast in all classrooms. The School Wellness Policy Committee also has adopted a new structure and plan based on best practices.

» In-classroom and outside-the-classroom student health education provided by PIH Health resident physicians and health educators. During the 2013–2014 school year, 43 health education sessions were provided for students, using a best practice-based curriculum throughout the district, focused on three themes: Think Healthy, Eat Healthy and Move Healthy. Through these lessons, students are engaged in hands-on learning about healthy eating and increased physical activity. Students also receive annual health screenings and vaccination clinics. Additionally, a PIH Health nurse regularly rechecks students with elevated blood pressure or other high-risk factors.

» Promotoras de Salud en Acción/Health Promoters in Action program. Through a parent leadership group based on the community health worker model, parents are trained as community health promoters to champion wellness initiatives, enhance school wellness policies and offer health education to families. As foundational skill building, promotoras de salud are trained in the Parents in Action curriculum, a joint program of the California Department of Public Health and the Public Health Institute, to read and dissect the schools' policies and identify gaps that need to be addressed. Promotoras de salud also train other parents to facilitate this program throughout the school district.

Results

To evaluate the long-term impact of Healthy Los Nietos, PIH Health and the Los Nietos School District longitudinally track body mass index (BMI) and blood pressure of first-, third-, fifth- and seventh-grade students. HLN also tracks students' health behavior modification and increased health-related knowledge based upon pre-and post-surveys.

During the 2014–2015 school year, fifth- and seventh-graders had an 84 percent increase in knowledge, based upon pre- and post-surveys (representing 1,958 students surveyed). For student health behaviors, 30 percent of third graders surveyed self-reported a decrease in viewing two or more hours of television two or more days per week. Also, 29 percent of third graders surveyed reported a decrease in eating junk food after school two or more days per week, and 24 percent reported an increase

in physical activity for at least one hour, two or more days per week. Paired analysis of students' BMIs tracked longitudinally has allowed HLN to identify unique ways to influence student health and wellness based on statistically significant data.

In 2015, the first year the Promotoras de Salud en Acción/Health Promoters in Action program was assessed, 100 percent of all members learned new skills to enhance health behavior and to promote health with other parents. HLN also surveys school faculty and staff to learn about their behavior, knowledge and perceptions and how the program has affected their students as well as what other improvements can be made. From 2013 to 2016, more than 56 percent of staff reported that HLN has influenced them to make overall healthier choices.

Lessons Learned

 » Hospital and schools are natural partners for healthy eating and physical activity initiatives. Schools are a natural convener of children and parents, and hospitals have resources that can be used to educate students and parents and implement programs related to nutrition and physical activity.

 » Implementing a formal and structured avenue for parent involvement can help support partnership goals by creating a clearer understanding of needs; strengthening bonds between parents, the district and community-based organizations; increasing buy-in and a shared sense of ownership for health; and utilizing community assets to address identified needs.

 » Sustainability of the partnership, tools and initiatives is key. Building in processes and procedures and providing unique opportunities to community-based organizations to expand their programs and services will help ensure the partnership and its programs can continue over time.

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Cook Children's Health Care System

Fort Worth, Texas

Background and Partnership Structure

Cook Children's Health Care System is a large, not-for-profit, integrated health care delivery system with more than 60 primary and specialty care offices throughout North Texas. The health system's Community Health Outreach Department (CHO) aligned with the Center for Children's Health and in 2008 surveyed the six-county region to identify children's health issues. The Community-wide Children's Healthy Assessment and Planning Survey (CCHAPS) was the first known project that focused specifically on the overall health status of children. Since then, this thorough survey is conducted every three years and results are publicly available. The priority needs identified from this survey and other sources have informed the formation of need-focused programing and community partnerships.

Partnerships with Cook Children's vary in their organizational and governance structures. Some partnerships are formalized and have structured reporting and operations; others are less formalized and guided more by the community partners. All of the partnerships were formed due to personal, expressed interest from community leaders and parents and informed by the survey results. This organic partner identification process produces a variety of leadership and professional skills. In its partnerships, Cook Children's does not claim to be the expert and instead allows for the community to take leadership on the initiatives with the hospital's support. The goal is to create programs that are sustainable and issue focused.

With a strong emphasis on using data to support programming and providing effective and engaged leadership, Cook Children's has successfully been the anchor institution for many coalitions and programs that address children's needs on important issues like mental health, substance abuse and healthy eating.

Community Programs

Cook Children's addresses community needs through a variety of strategic programs and coalitions. Each coalition has a strategic plan. These programs include:

» WATCH Coalition (Wellness Alliance for Total Children's Health of Denton County) works to increase awareness and access to mental health services for Denton County children. The coalition's strategic plan objectives include building community understanding of children's mental health, promoting mental health services, and improving access for these services to children and their families.

» Johnson County Alliance for Healthy Kids (JCAHK) facilitates community-based approaches to promote healthy nutrition and physical activity for Johnson County. To prevent childhood obesity, the coalition works to increase accessible and affordable opportunities throughout the community for children to eat healthy and increase their physical activity and to increase awareness about health and wellness.

» Wise Coalition for Healthy Children (WCHC) aims to promote healthy family relationships and engage the community to reduce physical abuse and neglect. WCHC uses evidence-based programs that assist parents and other caregivers by providing healthy parenting and nurturing skills. The coalition also is partnering with community agencies to expand parenting skills training and support services.

Results

Cook Children's continuously uses data to back decision-making and measure the progress and impact of community programs. The health system uses result-based accountability and keeps dashboards to observe and track specific metrics categorized by "How much did we do?" and "How well did we do it?" for each community program. Below are some examples of these dashboard metrics and the program results:

» In fiscal year 2015, the WATCH Coalition educated more than 170 providers on mental health practices and distributed more than 1,000 mental health improvement tools, which was 100 percent over the target goal. The Denton website had more than 1,000 unique visitors, measured using Google Analytics. More than 94 percent of coalition respondents agreed that adequate progress had been made in meeting the coalition's strategic plan objectives, and 95 percent of education event attendees reported they increased their knowledge about the event topic.

» In fiscal year 2014, JCAHK observed a 60 percent increase from baseline of children's knowledge about the recommended daily servings of fruits and vegetables. More than 1,000 children learned about healthy eating and physical activity. The estimated value of the alliance's 53 volunteers investing roughly 530 hours of time is $27,800.

Lessons Learned

Cook Children's has been working to make sustainable community partnerships. For every program, the motto has been: in the community, for the community, by the community.

» Do not take the medical or academic approach and instead approach a community need without the goal to "solve" the problem. This will allow leadership to think more creatively, with an open mind, and promote a grassroots movement that is more sustainable.

» Overcome institutional egos. The work is too important to allow for those kinds of road blocks. Always steer the agenda to what is in the best interest of the children and allow for flexibility.

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Duke University Hospital

Durham, North Carolina

Background and Partnership Structure

Duke University Hospital (DUH) is the predominant health care provider in Durham and the county's largest employer. Part of a full-service tertiary and quaternary academic medical center, DUH is the largest hospital in Duke University Health System. DUH benefits the community by providing highly regarded medical education programs, conducting research on new treatments to illnesses and diseases, and translating that research into population health improvement. DUH is an active partner with patients, neighborhoods, community organizations and governments to create innovative efforts to improve health and health care, including serving as a lead member in the Partnership for a Healthy Durham.

The Partnership for a Healthy Durham is the state-certified Healthy Carolinians partnership for Durham County, composed of more than 500 residents along with representatives from nonprofit and governmental organizations. Two volunteer co-chairs, along with the partnership coordinator and Durham County Department of Public Health leadership comprise the steering committee. The Durham County Department of Public Health provides programmatic support as a full-time coordinator while DUH provides financial and staff support to conduct the Durham County's community health assessment and develop strategies to address identified needs. The partnership has five committees which meet monthly, four of which are centered on health priorities identified in the 2014 community health assessment: access to health care, HIV/STIs, obesity and chronic illness, and substance use/mental health.

Community Programs

With a clear objective to build a Culture of Health, many collaborative community-engaged programs have emanated from the work of DUH, Durham County Department of Public Health, Lincoln Community Health Center and other members of the Partnership for a Healthy Durham, including:

» Project Access of Durham County (PADC). With $400,000 provided by the county, PADC links eligible low-income, uninsured residents to specialty medical care fully donated by the physicians, hospitals including DUH, labs, clinics and other participating providers. PADC also funds room and board amenities for the Medical Respite Program, which operates 24/7 and provides homeless patients with clean and safe housing that meets hospital's discharge standards.

» Local Access to Coordinated Healthcare (LATCH). This program was initiated in 2002 with Healthy Communities Access Program (HCAP) funding from the U.S. Health Resources and Services Administration (HRSA) and Duke's Division of

Community Health, Department of Community and Family Medicine. The LATCH partnership includes DUH (which now provides the majority of operating funds), Lincoln Community Health Center, Durham County Department of Public Health and Social Services, El Centro Hispano, and various community-based organizations. Through community-based, linguistically and culturally relevant care management, LATCH aims to improve health knowledge and self-care, access to health care, and health services utilization outcomes among the county's uninsured. Care management services include health services coordination and navigation (medical, social, behavioral); post-hospitalization follow-up; patient education; chronic disease management; psycho-social support; access to benefits (Medicaid/SSI/SSDI); bills assistance; interpretation/translation; and transportation coordination. In partnership with other community stakeholders—health care and social service providers, local government and community-based organizations—LATCH monitors health care trends, identifies barriers facing uninsured patients and addresses and eliminates barriers.

» Healthy Futures – Child Health Assessment and Prevention Program (CHAPP). This program was created to close gaps in access for children who have missed preventive well-child visits and immunizations, and reconnects these children and their families to supportive medical homes.

DUH with its Division of Community Health, Durham County Department of Public Health, and Durham Public Schools converted three DUH elementary school-based health centers and opened two additional ones utilizing enhanced role registered nurses to deliver well-child care to children who are overdue for checkups. The five sites are in areas that demonstrate significant gaps in pediatric care. DUH supports mental health services at all five sites and provides medical backup. Additionally, Healthy Futures clinics are satellite clinical services of the Durham County Department of Public Health.

In fiscal year 2016, the first full year of operation, the program aims to reduce the cost of well-child visits while expanding access to physicians for complex acute and chronic needs by ensuring both enhanced role registered nurses and primary care physicians are working at the top of their licenses. Child Health Assessment and Prevention Program evaluation metrics will include number of well child care visits; number of children referred to a medical home; number of vaccinations administrated; number of dental, hearing, vision referrals; and financial inputs and outputs to determine fiscal efficacy, sustainability, and expansion opportunities.

Results

Since 2011, Durham County has seen improvement in nine out of the 40 state of North Carolina objectives from Healthy People 2020, including a decrease in suicide, smoking and diabetes rates. In 2015, PADC provided services to more than 1,000 patients.

Additionally, LATCH had more than 6,000 care management service encounters with patients, showing a 17 percent decrease in hospitalizations. In their assessment of the partnership, the Annual Survey Evaluation of Community and Health System partners by Duke's Division of Community Health ascertained that 93 percent of partners are satisfied to highly satisfied with hospital and community organizations' contribution to the community.

Lessons Learned

» Durham County Department of Public Health utilized public health epidemiologists who collected and analyzed data from community health assessments to ensure validity and determine the impact of projects.

» Through transparent communication via focus groups and community advisory board meetings, Duke and its partners continue to implement more person- and place-based quality-driven services and interventions for all types of populations.

» Nurturing a Culture of Health involves concrete indigenous programs and services that improve community health and requires multiple sectors to systematically search for root causes and integrate solutions into clinical and or community settings.

» A collaborative multisectoral approach to understanding and improving community health enables academic health centers and other health institutions to reach out and develop community partnerships to promote health and fully realize their roles as "health" centers and not "disease" centers.

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West Tennessee Healthcare

Jackson, Tennessee

Background and Partnership Structure

West Tennessee Healthcare is a public, nonprofit health care system based in Jackson, Tennessee. With locations throughout 17 counties in West Tennessee, West Tennessee Healthcare includes four hospitals, an outpatient surgical facility, advanced care for women, advanced heart and vascular services, inpatient physical rehabilitation, cancer treatment center, emergency medical services, behavioral health, and many other services.

To help bring in more grant funding to the community, in 1995 West Tennessee Healthcare announced a community grant-writing program to draft and submit grant applications free of charge for public and nonprofit agencies within the West Tennessee Healthcare service area that wanted to fund projects that addressed community health needs. Since then, West Tennessee Healthcare has helped bring in $70 million of new money and $150 million of ongoing money for the community, securing funding for a variety of stakeholders, such as a local community college, after-school programs, alcohol and drug rehabilitation centers, the local chamber of commerce, and local parks.

In 1995, West Tennessee Healthcare conducted a community health needs assessment, looking at quantitative data and community surveys about perceptions of health needs. From the assessment, West Tennessee Healthcare's own committee prioritized children's access to health care.

Community Programs

» School Nurse Program. To address the prioritized needs of children's access to health care, West Tennessee Healthcare partnered with the Jackson-Madison County School District and the local health department to create a school nurse program and used its own funds to provide five full-time nurses during the first year. Today, West Tennessee Healthcare and the school district share the costs. West Tennessee Healthcare, the health department and the Jackson-Madison County School District mutually determined that the program would be administered through the school district, but the nurses would be employed by the health department. Over time, it was decided that the school district would employ the nurses and bind all legal agreements for the program. Nurses in the 27 schools assess children's health status, helping to diagnose students before illnesses progress and stopping the spread of contagious diseases. The nurses determine if children need to go home or can receive appropriate care and return to the classroom. The program is financially beneficial for the school district because the state distributes money based on student attendance (about $2,500 per student).

At the beginning of each school year, parents fill out health histories for their children. If a child has a chronic disease, the school nurse partners with the parent and the child's doctor(s) to work on an individualized health care plan. Through this process, the school district has realized that many children do not have a primary care provider. In response, the district and West Tennessee Healthcare have created a school-based clinic staffed with a full-time pediatric nurse practitioner and a licensed practical nurse, open to any student or employee from the district.

West Tennessee Healthcare provides the staff, equipment and furniture, while the district supplies the facility space. West Tennessee Healthcare also provides athletic trainers at no cost to all of the secondary schools, and these trainers cover sporting events. In addition, West Tennessee Healthcare's mental health, physical, occupational, and speech therapists work with students, including those with special needs.

To make its schools healthier, the school district has launched nutrition initiatives, such as banning sugary beverages, candy bars and potato chips at schools. Additionally, the school district holds educational programs at the West Tennessee Healthcare LIFT (Living in a Fit Tennessee) wellness center for students, parents and staff.

Results

The school nurses' services are widely used. In the 2014–2015 school year, the 13 nurses had 33,000 visits. The program has proved to be effective in boosting attendance; when a nurse is present, the children return back to class about 80 percent of the time. Increased attendance means that students are not as likely to miss important information in their classes. Parents also benefit since they are less likely to need to take time off work to care for an ill child. Furthermore, because of high attendance and success rates, schools are able to receive more funding every year.

Additionally, at a time when childhood obesity and overweight rates are rising, students from the district are showing a decrease in high body mass index (BMI). From the 2008–2009 school year to the 2012-2013 school year, the percentage of children with a higher than normal BMI fell from 46 percent to 40 percent.

Lessons Learned

» Depending on availability and convenience, hospitals and community partners can each offer different resources – be it financial, staffing, in kind, or facilities.

   » For example, West Tennessee Healthcare partnered with transitional facilities to hold homeless individuals with medical issues because other homeless shelters refused to assist them.

» Acquiring funding can become a barrier. Therefore, West Tennessee Healthcare continues to conduct research on available resources in the community – such as health care systems, churches, schools and nonprofit organizations – to recruit potential partners.

» West Tennessee Healthcare experienced the need to serve as a convener and a positive facilitator when working with different agencies and perspectives.

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Montrose Memorial Hospital

Montrose, Colorado

Background and Partnership Structure

Montrose Memorial Hospital (MMH) is a nonprofit, community-based hospital with 75 beds and 100 physicians. The second largest employer in Montrose, Colorado, MMH has more than 680 employees and serves Montrose, San Miguel and Ouray counties. MMH's community engagement efforts are founded on the belief that success happens when the community views the hospital as a collaborative partner and a good neighbor.

MMH works with many different strategic partners in the community including the Montrose Economic Development Corporation Board, Montrose County School District, and Montrose Arts Council Board.

MMH has structured its partnership initiatives in several different ways, such as joint ventures and oversight committees, to help navigate community engagement.

Community Programs

MMH organizes and sponsors several different community health programs. These programs include ergonomic space awareness, local health fairs, school-based health center, speakers' bureau and sponsorship of Girls on the Run. One of MMH's flagship programs is a school-to-career program with the Montrose County School District.

» Montrose County School District. Working with the local school district, MMH provides a career options seminar and career fairs for students. In the career programming, the hospital and school district offer students 16 possible career clusters in health sciences, management and administration, and marketing and business. Students in grades 9 through 12 can work for academic credit while also having a career internship. Students working at MMH must commit to four days a week for 1.5 hours a day, and students rotate between departments. MMH requires a workers' compensation liability contract and a parent/student contract.

» School-based health center. In collaboration with the Center for Mental Health, MMH helped organize two school-based health centers which offer mental health care for children, with services available on-site at the school to all students and overseen by MMH clinical practitioners. The need for this care was identified after students were missing school days because of mental health illness or the inability to afford visits to a physician.

> » Community health fair. MMH runs a yearly health fair and blood draw, with more than 3,500 people participating in the blood draws and receiving blood tests at an extremely low cost. During the health fairs, MMH staff and other community providers provide a variety of free health screenings.

Results

MMH has seen solid results in many of its community engagement programs. For example, the career training in the Montrose County School District has been very successful. In the career program, 1,200 students have attended the career options seminar in the school district, with about 300 students a year participating. Every year, 60 students participate in the health sciences cluster, with 24 students completing their work at MMH.

Lessons Learned

> » Communication is key between the students, work sites and parents to understand the requirements and benefits of the career program.

> » Each student's experience is only as good as his or her preceptor(s) and interest level.

> » For students working at MMH, orientation must be basic and specific.

> » All partners must be committed to make the program successful, including investing time and talents, not just money.

> » Career programs can have lasting positive effects on the community, with trained health professionals staying in the community.

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Appendix A: Survey Methodology

Survey Data

The Association for Community Health Improvement (ACHI) of the American Hospital Association (AHA), in collaboration with the Population Health Institute, created this 2015 population health survey. The questionnaire was mailed to 6,365 hospitals across the United States. A total of 1,418 hospitals completed the survey questionnaire between January and May 2015, for a 22 percent response rate.

This survey collected information on each hospital's demographics, population health structures, partnerships and community health needs assessments. To determine partnership types and levels, one section of the survey asked, "Please describe your hospital's current working relationship with each type of organization listed below." Thirty-nine partnership types were identified, listed in Figure 11, and respondents were asked to rank their partnership level with each type of partner. Partnership levels included "not involved," "funding," "networking," "collaboration" and "alliance."

Figure 11: Partnership Types from AHA/ACHI Population Health Survey

a. Other local hospitals or health care systems
b. Local (municipal, city or county) government
1. Office of the chief elected official
2. Office of the municipal, city or county manager
3. Public health
4. Human services (separate from public health department)
5. Public hospital/health care system
6. Public safety
7. Housing/community development
8. Policy/legislative initiatives
9. Transportation
10. Other (please describe)

c. State agencies
1. Office of the governor
2. Public health department
3. Human services (separate from public health department)
4. Public hospital/health care system
5. Housing/community development
6. Public safety
7. Policy/legislative initiatives
8. Transportation
9. Other (please describe)

d. Other agencies
1. Federal government direct relationship (e.g., nutrition programs)
2. Tribal and Indian health
3. World Health Organization
4. National health associations (e.g., heart, lung, diabetes or cancer associations)
5. Federally qualified health center, community health center, rural health clinic or free clinic
6. Healthy communities coalitions
7. Health insurance companies
8. Retail clinics (e.g., Walgreens, CVS, Rite Aid)
9. Faith-based organizations
10. Early childhood education
11. School districts (primary and secondary education)
12. Post-secondary education (colleges, universities)
13. Chamber of commerce or other business group
14. Local businesses
15. Service leagues (e.g., Lions, Rotary)
16. Neighborhood organizations
17. United Way
18. YMCA/YWCA
19. Other (please describe)

Source: AHA/ACHI, 2015.

Interviews

The Health Research & Educational Trust (HRET) used the self-reported survey information to identify 25 hospitals with a range of partner types and partnership levels. These 25 hospitals varied in location, service type, bed size, type of partners and degree of partnership.

HRET invited leaders from each of the 25 selected hospitals to participate in a 60-minute interview. An interview guide was developed and followed for these interviews. Questions covered such topics as roles of each partner, resources provided by each partner, community needs addressed, implementation approaches, partnership success factors, lessons learned and results from the partnership.

At the conclusion of each interview, HRET asked interviewees to provide names and contact information for one to two of their hospital's community partners. HRET then conducted a similar interview with the community partner(s).

All interviews were recorded, transcribed and analyzed to identify common themes and innovative approaches. The transcriptions were qualitatively analyzed using ATLAS.ti 7 (Thousand Oaks, Calif.). Twenty-nine unique codes were identified and defined by the research team based on a preliminary reading of sample transcripts. Intercoder reliability between five coders was assessed using Fleiss' kappa. Documents were recoded until $\kappa > 0.75$.

HRET also collected and reviewed documents related to the collaboration, which were provided by hospitals and community organizations following the interview process.

Appendix B: Partnership Results from the AHA/ACHI Population Health Survey

The American Hospital Association, in partnership with the Association for Community Health Improvement, distributed a population health survey to all hospitals in the United States (n= 6,365) in January 2015. The survey was in the field for five months and had a 22 percent response rate (n=1,418). Sample was representative of the U.S. hospital field, with nonprofit, large and teaching hospitals slightly overrepresented. The survey included questions regarding population health structure and alignment, partnerships and community health needs assessments. Full results can be found at www.hpoe.org/pophealthsurvey.

To assess the range of partnership types that hospitals have established with community organizations, the survey used a five-point scale. The categories were:

Not involved — No current partnerships with this type of organization

Funding — Grant-making capacity only

Networking — Exchange ideas and information

Collaboration — Exchange information and share resources to alter activities and enhance the capacity of the other partner

Alliance — Formalized partnership (i.e., binding agreement) among multiple organizations with merged initiatives, common goals and metrics

Figure 12: Partnerships with Other Hospitals

| 12.8% | 0.4% | 23.0% | 43.5% | 20.3% |

n=1,418

■ Not involved ■ Funding ■ Networking ■ Collaboration ■ Alliance
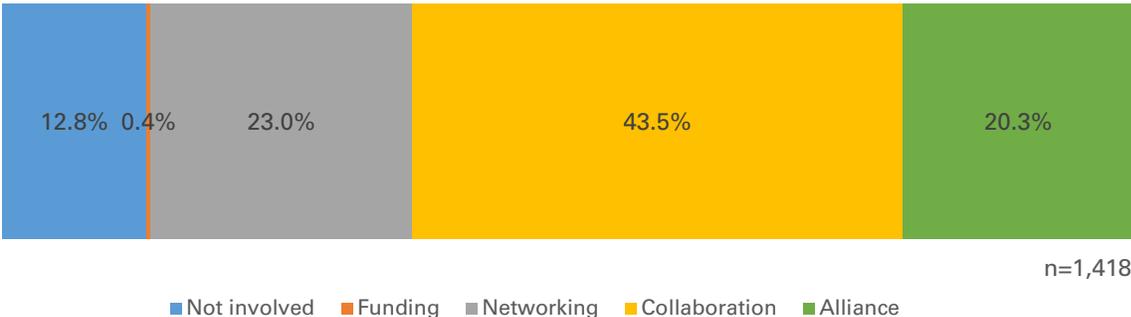
Source: AHA/ACHI, 2015.

Figure 13: Partnerships with Local Government

Categories (top to bottom): Public hospital, Public health, Office of the municipal, city or county manager, Public safety, Human services, Policy/legislative initiatives, Office of the chief elected official, Housing/community development, Transportation

Legend: ■ Not involved ■ Funding ■ Networking ■ Collaboration ■ Alliance

n=1,418
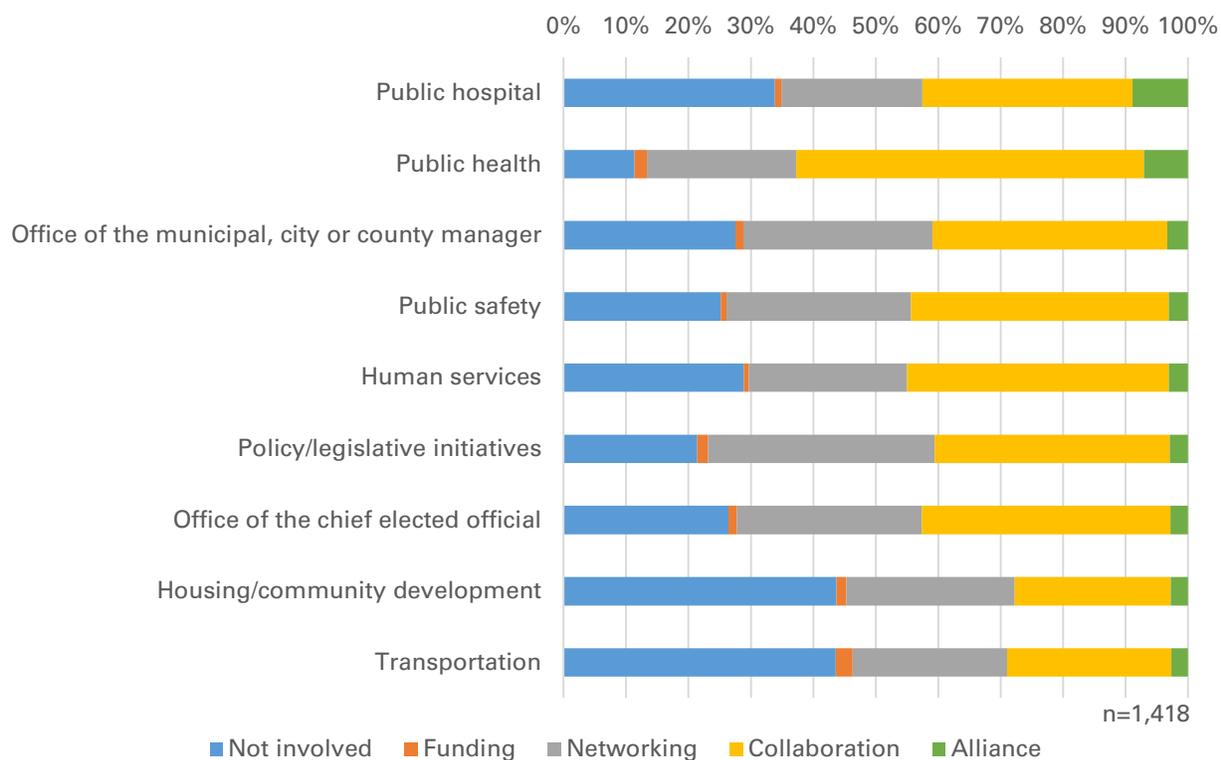
Source: AHA/ACHI, 2015.

Figure 14: Partnerships with State Agencies

Categories (top to bottom): Public hospital/health care system, Public health department, Human services, Office of the governor, Policy/legislative initiatives, Public safety, Housing/community development, Transportation

Legend: ■ Not involved ■ Funding ■ Networking ■ Collaboration ■ Alliance

n=1,418
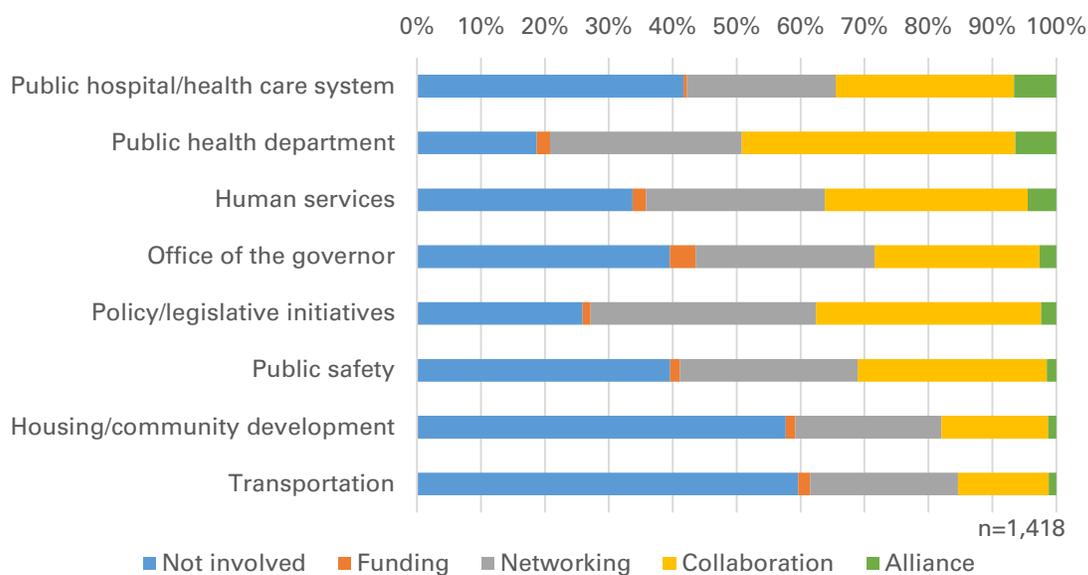
Source: AHA/ACHI, 2015.

Figure 15: Partnerships with Other Agencies

Legend: Not involved, Funding, Networking, Collaboration, Alliance

n=1,418

Categories (top to bottom):
- FQHC, community health center, etc.
- Health insurance companies
- Post-secondary education (colleges, universities)
- Healthy communities coalitions
- School districts
- Retail clinics
- Faith-based organizations
- Chamber of commerce
- Federal government programs (e.g., nutrition)
- United Way
- Local businesses
- YMCA/YWCA
- National health associations
- Early childhood education
- Service leagues
- Neighborhood organizations

Source: AHA/ACHI, 2015.

Appendix C: The Hospital's Role in Partnerships

Previously, the Health Research & Educational Trust (HRET) developed the framework shown in Figure 16 to outline possible roles that hospitals may take in working with community partners. Hospitals, their community partners or a separate "backbone" organization may play one or more of these roles for their Culture of Health initiatives. The specific role of each organization may vary based on the intervention, community need, and resources or expertise of the organization. Additional information about these roles can be found in the leadership guide "Hospital-based Strategies for Creating a Culture of Health," available at http://hpoe.org/cultureofhealth.

Figure 16: Hospital Roles for Building a Culture of Health

Intervention Scope

Targeted ←————————→ Comprehensive

Broad

Degree of Collaboration

| Convener | Anchor |
| Specialist | Promoter |

Focused

» **Specialist**: Concentrates on a few specific issues

» **Promoter**: Supports other organizations' initiatives

» **Convener**: Brings together hospital and community stakeholders

» **Anchor**: Leads initiatives to build a Culture of Health
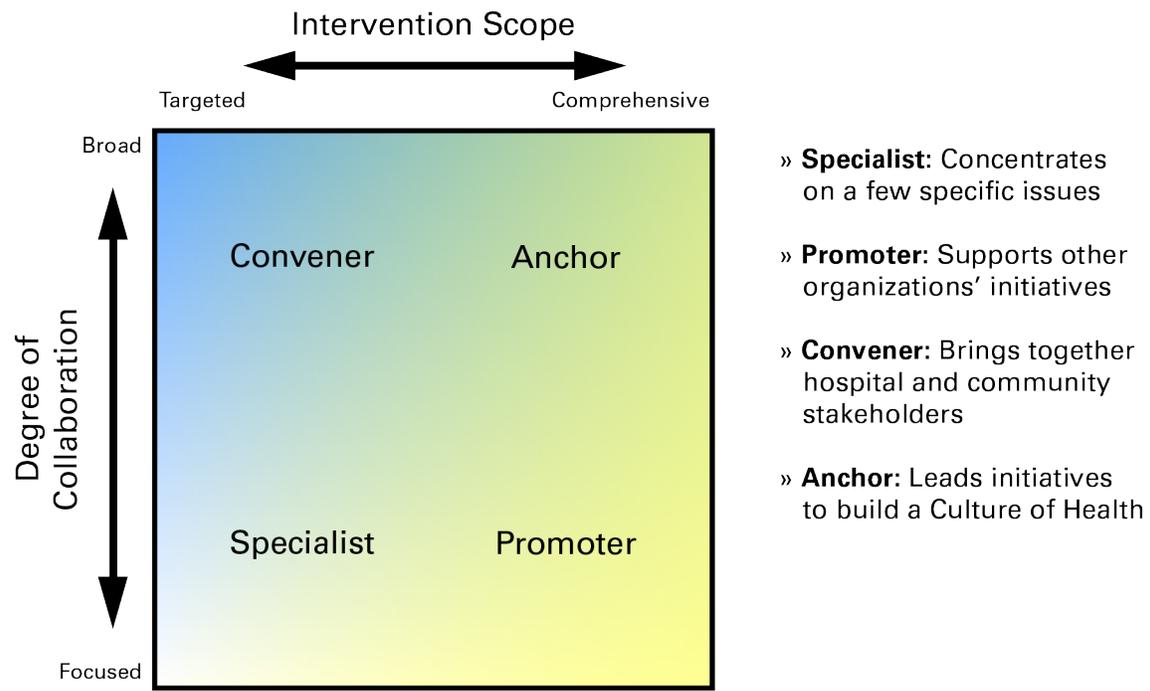
Source: HRET, 2014.

Hospital and community organizations interviewed by HRET reflect the wide variety of approaches to partnership types. Many of the hospitals viewed themselves as anchor institutions within the community, especially if the community is a rural area.

Highly collaborative approaches with a broad scope of interventions may have a greater impact on population health because such approaches engage the community to a greater extent and focus on a wide range of health and socioeconomic needs. Not all hospitals can or should be anchors, and a neutral backbone organization may be best positioned to play that role. In some cases, the hospital may be best suited to convene other key players; but in other instances, the coalition or steering committee may be the best entity to bring together all stakeholders. The other roles identified, while perhaps more targeted in their approach, have the potential to make a significant impact on community health. Each partner (including the hospital) needs to determine the best role for its organization based on the specific situation.

Appendix D: Health Impact Collaborative of Cook County Survey

The [Health Impact Collaborative of Cook County](#) is a partnership between the Illinois Public Health Institute, hospitals, local health departments and community organizations across Chicago and Cook County, Illinois. This collaborative uses a survey to examine the effectiveness of its partnerships. The purpose of the survey is to better understand each partner's background and perceptions about the collaborative's activities. The survey covers the following categories:

Background:

» Questions on current and prior experience

» Questions on operations and logistics, such as number of meetings and details on types and roles of members

» Questions on the collaborative's alignment with the organization's CHNA/CHA

Barriers and Facilitators:

» Barriers to the organization joining the collaborative

» Barriers to getting regional leadership team members to work together

» Questions on what facilitated the organization to join the collaborative

Collective Impact — Backbone Structure:

» Level of agreement with the functions, alignment and management of the backbone structure

Collective Impact — Shared Measurement System:

» Level of agreement with the shared measurement and the process to determine a common set of indicators and data collection methods and understanding of the value

Collective Impact — Continuous Communication:

» Level of agreement on questions related to engagement, participation and communication of steering committee and regional leadership teams, partners and external stakeholders

» Level of agreement on elements related to collective impact, including clear communication of geographic boundaries, goals and roles

Collective Impact — Collaborative Capacity:

» Level of agreement on questions about operating support, influencers and champions, and leadership

Collective Impact — Learning Culture:

- » Level of agreement on learning structures and processes, decision-making, feed-back, and respect for diversity

- » Level of agreement related to organizational engagement, including leadership support and commitment to act

For more information about this survey, contact Kusuma Madamala at madamalak@gmail.com.

Appendix E: Duke Health Division of Community Health Partnership Survey

Duke Health's Division of Community Health created a partnership evaluation survey to learn about its partners' satisfaction with the partnership and the partnership's impact.

1. How have you been involved with the Division of Community Health, its faculty and staff, or its programs? Please mark all that apply:

   ☐ Participate(d) in a coalition together

   ☐ Work(ed) together on a grant proposal

   ☐ Work(ed) together on a grant-funded project

   ☐ Work(ed) together on a nongrant-funded project

   ☐ Work(ed) together running or implementing a clinical, care management, health promotion or other community health program

   ☐ Work(ed) together on a research study

   ☐ Contract(ed) with the Division of Community Health to conduct a program evaluation

   ☐ The Division of Community Health has been involved in our training program(s)

   ☐ Work(ed) together running or implementing an education/training program

   ☐ The Division of Community Health has been a subcontractor to us

   ☐ We have been a subcontractor to the Division of Community Health

   ☐ Other_____

2. On a scale from 1 to 5, with 1 being "not satisfied at all" and 5 being "highly satisfied", how satisfied have you been with the contribution that partnering with the Division of Community Health makes to:

	Not satisfied at all 1	2	3	4	Highly satisfied 5
Carrying out your core mission?					
Reaching people with your services or message?					
The quality and effectiveness of your work?					
Your capacity to take on new efforts?					

If you would like to explain any of your answers, please do so:

3. On a scale from 1 to 5, with 1 being "not at all" and 5 being "a lot", to what extent has the Division of Community Health contributed positively to the following? (Choose N/A if you are not in a position to comment).

	Not at all 1	2	3	4	A lot 5	N/A
Collaboration between Duke Medicine and your community?						
Access to primary care in your community?						
The health of your community?						
Collaboration in your community?						
Community capacity-building?						
Understanding of health care delivery system in your community?						
The training of health care professionals and students?						
Practitioner or researcher knowledge of community health needs?						
Practitioner or researcher knowledge of approaches to improving community health?						

If you would like to explain any of your answers, please do so:

4. On a scale of 1 to 5, with 1 being "Not satisfied at all" and 5 being "Highly satisfied" how satisfied have you been with your partnership with the Division of Community Health over the past year?

___1 (Not satisfied at all)   ___2   ___3   ___4   ___5 (Highly satisfied)

If you would like to explain your answer, please do so:

5. Is there anything you would like to add about the impact of the Division of Community Health on your work or the larger community?

6. How can the Division of Community Health make other entities at Duke aware of our services?

7. How can the Division of Community Health make other entities in the community aware of our services?

8. How can the Division of Community Health improve its work overall?

Source: Duke Health, 2016. Reprinted with permission.

For additional information, contact Michelle J. Lyn at michelle.lyn@duke.edu.

Appendix F: Coalition Member Assessment

Created by Tom Wolff and Gillian Kaye, this assessment is a variation of earlier satisfaction surveys. Members rate their coalition on a 1 to 5 scale, from "strongly agree" to "strongly disagree," answering 44 rated questions and several open-ended questions. Questions cover preferred level of involvement, partnership vision, leadership and membership, structure, communication, activities, outcomes, relationships, personal and organizational benefit from participating, and areas for improvement. This survey can also be found at http://www.tomwolff.com/coalitionmemberassessment.htm.

Figure 17: Coalition Member Assessment

1. Vision: Planning, Implementation, Progress	Strongly Agree				Strongly Disagree
The coalition has a clear vision and mission	1	2	3	4	5
There is consistent follow-through on coalition activities	1	2	3	4	5
The coalition utilizes activities that are effective in helping the coalition reach its goals	1	2	3	4	5
The coalition has developed targeted action planning for community and systems change	1	2	3	4	5
The coalition effectively reconciles differences among members	1	2	3	4	5
The coalition engages in collaborative problem-solving of jointly shared problems, resulting in innovative solutions	1	2	3	4	5
The coalition expands available resources by having partners bring resources to the table or identify others with resources	1	2	3	4	5

2. Leadership and Membership	Strongly Agree				Strongly Disagree
The coalition develops and supports leadership	1	2	3	4	5
There are opportunities for coalition members to take leadership roles and members are willing to take them	1	2	3	4	5
Leadership responsibilities are shared in the coalition	1	2	3	4	5
The coalition creates greater ownership by partners in joint ventures and projects	1	2	3	4	5
The coalition has broad and appropriate membership for the issue it is addressing	1	2	3	4	5
The coalition membership is diverse	1	2	3	4	5
Members display commitment and take on tasks	1	2	3	4	5
3. Structure	Strongly Agree				Strongly Disagree
The coalition has regular meeting cycles that members can expect	1	2	3	4	5
The coalition has active workgroups and committees	1	2	3	4	5
Members get agendas for the meetings prior to the meeting and minutes afterwards	1	2	3	4	5
The work of the meeting, as outlined in the agenda, gets accomplished	1	2	3	4	5
The coalition has a viable organization structure that functions competently	1	2	3	4	5

4. Communication	Strongly Agree				Strongly Disagree
Communication among members of the coalition is effective	1	2	3	4	5
Communication between the coalition and the broader prevention community is effective	1	2	3	4	5
Coalition members are listened to and heard	1	2	3	4	5
5. Activities	Strongly Agree				Strongly Disagree
Information gets exchanged at coalition meetings	1	2	3	4	5
The coalition develops new materials and new programs	1	2	3	4	5
The coalition advocates for change	1	2	3	4	5
New and more perspectives are shared on issues	1	2	3	4	5
Outcomes are more comprehensive than those achieved without a coalition	1	2	3	4	5
6. Outcomes	Strongly Agree				Strongly Disagree
The coalition has been able to achieve its goals and create concrete outcomes	1	2	3	4	5
The coalition is serving as a catalyst for positive change related to the issues it has chosen to work on	1	2	3	4	5
The coalition creates community changes as seen in changes in programs, policies and practices that enhance people's lives	1	2	3	4	5

The coalition has effected changes in programs, policies and practices in many sectors and systems in the community related to the issues it has chosen to work on	1	2	3	4	5
The outcomes created are the ones that matter	1	2	3	4	5
After each activity or project the leadership of the committee evaluates how it went in order to learn from experience	1	2	3	4	5
What changes occurred because of the coalition that otherwise would not have occurred?					
What specific changes in programs, policies and practices have you seen that were created by the work of this coalition?					
7. Relationships	Strongly Agree				Strongly Disagree
Old or existing partnerships have been enhanced as a result of the coalition	1	2	3	4	5
We have built new relationships with new partners as a result of the coalition	1	2	3	4	5
Members of the community related to the issues now know more about each other's resources as a result of the coalition	1	2	3	4	5
8. Systems Outcomes	Strongly Agree				Strongly Disagree
As a result of the coalition's formation, system changes have happened, including changes in relationships in the larger community that works on the issues the coalition has identified and in the capacity of the coalition to address emerging issues	1	2	3	4	5

	Strongly Agree				Strongly Disagree
We have seen positive changes in the community that works on our issue(s) as a result of the coalition: partners are more collaborative and more cooperative	1	2	3	4	5
The coalition helped the people in the community access more research both within and outside the coalition in order to reach their goals	1	2	3	4	5
9. Benefits from Participation	Strongly Agree				Strongly Disagree
The community and its residents are better off today because of this coalition	1	2	3	4	5

I have benefited from participation in the coalition through: (check all that apply)

☐ Building relationships with other coalition members

☐ Exchanging information with others — networking

☐ Working with others on issues of importance

☐ Being part of a process that brings about meaningful change

My agency has benefited from its participation in the coalition through: (check all that apply)

☐ Modified programs

☐ Developing new programs

☐ Gaining access to new or more resources

☐ Creating solutions collaboratively with other coalition partners

What changes happened in your own organization as a result of the coalition that would not otherwise have occurred?

What happened that surprised you that you did not plan for as an outcome?

As a result of the coalition work, what are the three most significant things you have learned?

Resources

American Hospital Association and Affiliates

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Other Resources

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