How Health Sectors Can Leverage Partnerships

JOHN MORRISSEY

Health care organizations and public health agencies have operated in parallel for many decades, brushing up against each other at times of crisis or, occasionally, building on mutual interests. Public health departments often address health problems that arise from chronic or infectious illnesses and are aggravated by negative neighborhood and home circumstances. Health care providers have had to adjust their focus away from reacting to illness and toward intervening in people's lives to lessen chronic conditions, though their influence wanes once patients go home to a host of nonmedical threats to health.

Overlapping objectives of these two health sectors should be obvious, and the collaborative potential evident. But health care delivery and public health face natural barriers to partnering in inventive ways to improve individual and population health. The teamwork necessary to target ills as complicated as asthma, diabetes and behavioral illness — or address factors such as obesity, homelessness and bad nutrition — won't succeed if partners can't rise above themselves.

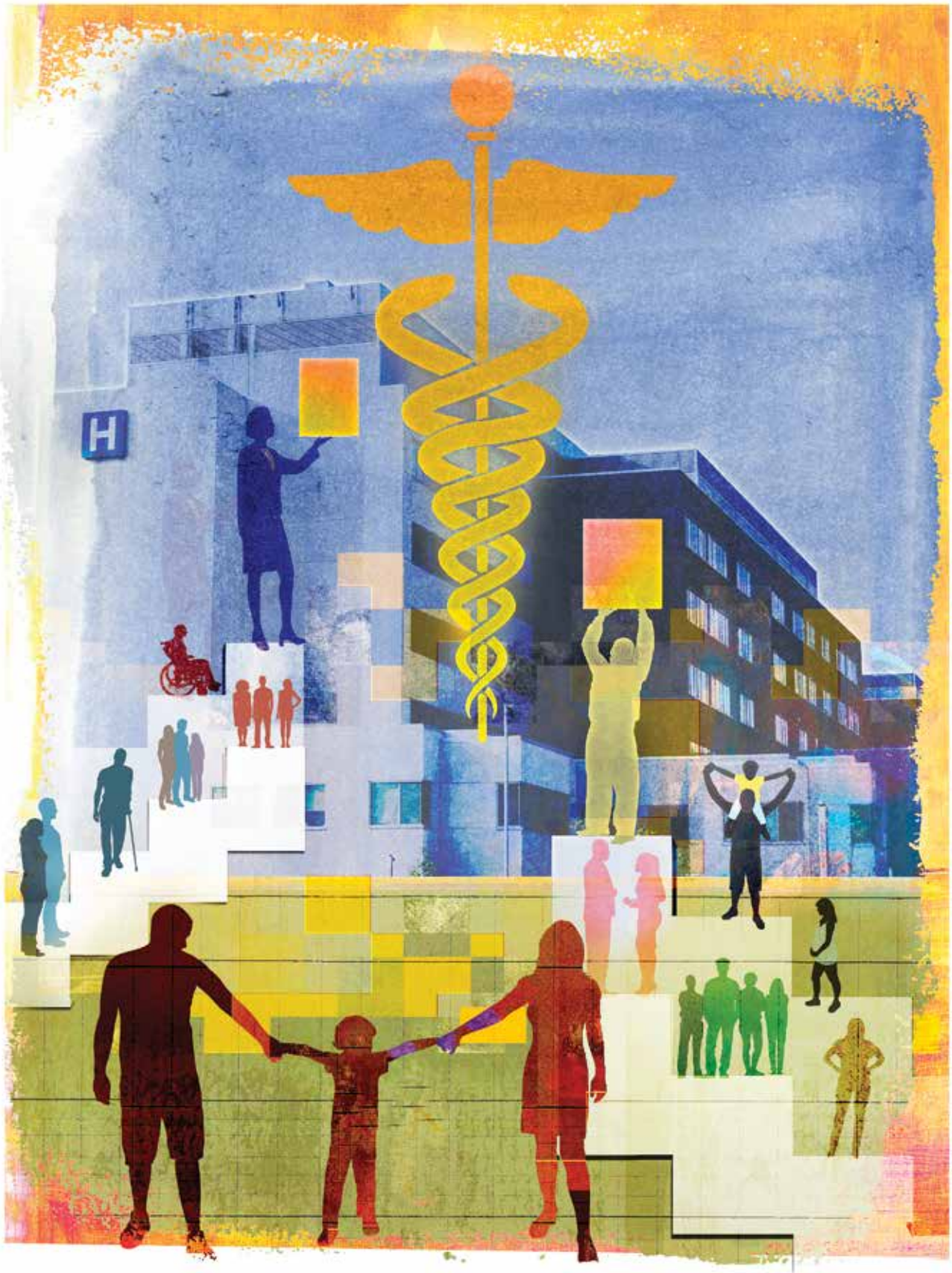
"I see control concerns not just in health care organizations, but also in the governmental public health agencies," said Glen P. Mays, PhD, MPH, professor in health services and systems research at University of Kentucky College of Public Health in Lexington. "There's a reluctance to give up control, particularly when organizations are contributing resources into a collaborative activity."

Until those barriers to collaboration recede, health care leaders who see community collaboration as vital can draw on other possibilities that may be more promising, as well as a more natural fit for the biggest targets of their neighborhood outreach. Across the country, hospitals have formed innovative initiatives with organizations dedicated to community benefit, involving groups set up to solve specific social problems as well as those with basic duties to protect, educate and enhance the lives of the citizenry.

WHICH ISSUE?

The most logical first consideration in establishing such partnerships is not whom to collaborate with, but, rather, what issue to take on — then who might be out there to help, Mays observed. The aim of the initiative dictates the community resources to approach.

A California hospital lessened health problems among a sizable homeless population by partnering with a group that provides up to six months of housing for people who need a place to recuperate and receive medical treatment. Their health care needs had been forcing them into emergency rooms over and over.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Because chronically poor nutrition abets obesity, hospital leaders in Springfield, Massachusetts, organized initiatives to make healthy food easily available and affordable. Mercy Medical Center's leadership is investing money to process locally grown food for distribution and foster soil-free urban farming methods.

Many health problems originate in childhood and adolescence, and a Louisiana health care system has sponsored and helped operate health centers in Baton Rouge schools. Activities include screening to catch and lessen budding life problems ranging from diabetes and asthma to mental illnesses. Subsidized legal aid has helped get landlords to fix illness-inducing conditions that children go home to daily.

Seeking better life conditions for highly compromised patients once their intensive hospital care ends, an Arizona network lined up community partners — each with a particular strength to contribute — to carry the intensity of care back home for both infants with severe health conditions and trauma victims with permanent disabilities.

By integrating community groups into a hospital's clinical environment and enmeshing clinicians into the community via these organizations, "it's about empowering not only the hospital, but governmental agencies, nongovernmental citizenry, nonprofits, for-profits, to come together, to actually look at issues that are compelling and to be able to work on them together," said Marisue Garganta, director of community health integration for the Arizona Communities of Care Network, operated by Dignity Health-St. Joseph's Hospital and Medical Center, Phoenix.

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FINDING SYNERGIES

Potential partners don't always have the same missions, said Brian Castrucci, CEO of the de Beaumont Foundation, a group based in Bethesda, Maryland, whose purpose is to strengthen and transform public health.

But common ground is expanding.

"The only way for hospitals to achieve what they want, which is reduced cost and better patient experience, is to work with the community on what it wants, which is a better life experience, a healthy life experience," Castrucci said. "And the only way to do that is to find the synergies. There are things that only clinical medicine can do. There are things that only public health can do."

The lack of a basic cross-cultural understanding of other sectors often stands in the way, said Mays. "There are a lot of places where these systems don't connect very tightly or very productively."

For example, the public health sector typically focuses on broad-based population health needs and how to intervene, which often is not in tune with what hospitals are incentivized and paid to do. The payoff for fundamental health improvement is years away. Though health care is moving toward demonstrating that fundamental value, "we don't have value-based payment systems, even full-risk systems, that can account for that longitudinal nature of some of these population health interventions," Mays observed.

For hospitals that want to dedicate themselves to value in community health, however, assumptions that public health agencies will help move hospitals toward population health might not pan out, said Michael Stoto, PhD, professor of health systems administration and population health at Georgetown University in Washington, D.C. It's not clear that public health has been doing a lot of the community-based health improvement ascribed to it.

Rather than, say, working for heart disease prevention by promoting exercise and safe sidewalks in concert with community groups, a public health department might be more centered on well baby and child health, infection control and

treatment, immunizations and health inspections, Stoto said.

These categorical programs are important if only because no other entity is attending to them, said Mays, but they aren't the most valuable types of population health activities to contribute. Public health should have deep expertise and capacity in two key areas — community health assessment and epidemiological investigation — with strong data systems for monitoring health regionally, he said.

Health systems could benefit from not just their own claims-based data, but also richer data sources such as syndromic surveillance and population-based surveys from public health that can give "high-frequency insight into health issues emerging and progressing in the community," Mays said. But if those public health assets are not strong, health systems have to go somewhere else for them, perhaps a state-level health agency, a local university or freestanding public health institute, he advised.

ROBUST COLLABORATION

When it comes to devising a community-collaboration strategy, "It's nice to talk about hospital-public health collaboration, but to really make a significant impact, it's got to include that, but be broader than that," said Lawrence Prybil, PhD, retired professor at the University of Kentucky College of Public Health and an authority on multisector health care collaboration. He sees as "a good thing" the value of local hospitals collaborating with local health agencies, "but it's too narrow, it's not robust enough."

An inquiry co-led by Prybil for the Commonwealth Center for Governance Studies found that successful health-related partnerships included community stakeholders that went far beyond hospitals and public health departments. Success was not easy to come by; an initial list of 160 nominated initiatives was distilled down to 17 with "a healthy quotient" of the eight characteristics of success developed by the 2012 inquiry, which was published in 2014.[1]

Given that participating hospitals in the study provided 70 percent of the funding for their partnerships, multisector initiatives "are almost certainly not going to be successful unless the local hospitals are engaged," Prybil said.

They have the resources, expertise and mission required, but they can't do it by themselves.

"We've got to get the business community involved, they have a direct interest in this," he said. "We've got to get the school systems involved, we've got to get local government involved, we've got to get the darned insurers involved."

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— LAWRENCE PRYBIL, PhD

Prybil noted that a large proportion of public health agencies are underfunded. And on the health system side, "hospital payers don't have much of a focus on including community health improvement financing in the payment systems for patient care services."

Mays has been conducting a study for 20 years that follows how 600 communities around the country develop multisector networks, and only about 20 percent have a strong, successful coalition underway by the study's measures. They tend to start small around a single topic, and "successful ones are able to grow over time, bring in more partners, move on to other issues and begin to be really strategic and adaptable ... making smart decisions about where to spend their energies," Mays explained.

Strong partnerships show results. "If these coalitions can hold it together for about 10 years, we see a substantial reduction in preventable mortality. We also see a substantial reduction in medical care spending in these communities," Mays reported. A 2016 study headed by Mays in *Health Affairs* reported an 8 percent decrease in rates of preventable deaths where communities expanded population health activities through multisector networks.[2] A December 2017 study co-led by Mays and published in *Health Services Research* detailed the decrease in medical care costs.[3]

COMMUNITY HEALTH NEEDS

An underutilized starting point to define benefi-

cial partnerships is the community health needs assessment. Not-for-profit hospitals routinely have put these assessments together as a condition of tax-exempt status, and the Affordable Care Act kicked the intensity up a notch, including measures that expressly require hospitals to work with public health departments and community groups with a health-related purpose.

The mandate for community benefit in lieu of taxes is long-standing, and dollar-value compilations of uncompensated care have been the old standby. But the ACA's drive to reduce the ranks of people who are uninsured presumed a drop in uncompensated care. That raised the issue of how to reallocate some of that free-care money into upstream health factors with eventual benefit back to hospitals in better outcomes, said Stoto.

"That's the kind of theory that seems to have been lost," he said.

There is little attention paid to how the system could be pivoting to enlist community benefit activities in the transformation to health care value.

The needs assessment typically is done off to the side by government relations and community outreach people, and it is not connected to the mainstream of hospital board and executive planning, Stoto observed. For health systems lacking a plan to stage community collaboration, the needs assessment is a way to do so, but only if it is integrated with strategic thinkers, he said. It's a potential backbone for mutually reinforcing activities and continuous communication with the outside community and its ready resources.

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The needs assessment provides information on community health care issues as well as on what types and volume of medical issues the hospital is seeing, said Garganta of Arizona Communities of Care. Analysis on who was using the emergency department and outpatient sites revealed a picture of St. Joseph's obligation to support people beyond the hospital. When the needs assessment examined access to care and laid that across the population served, St. Joseph's observed high utilization by homeless people and calculated that it saw more homeless people than any other hospital in Arizona, Garganta said.

The hospital amassed an affinity group for health and housing for medically vulnerable people, looked at where they were being discharged to, what services were missing and what gaps and capacities needed attention. It hatched one initiative after another that touched the problem one way or another, and recently merged seven programs into one comprehensive undertaking that enables access to housing and addresses medical, social and psychological needs.

FROM SMALL TO FAR AND WIDE

The wisdom of starting small and gradually going far and wide is embodied in five diverse community services initiatives overseen by Barry Ross as vice president of healthy communities at St. Joseph Health's St. Jude Medical Center in Fullerton, California.

Ross started working in a community benefit role 18 years ago by seeking out those already working on important issues in the cities that the hospital organization serves. At the time he didn't find much but a small, grant-funded group running a Healthy Start program in Fullerton. He joined it, got to know the people and found interest in addressing other issues as the grant expired. Ross got involved in the leadership, eventually helping it become a not-for-profit 501(c)(3) community collaborative in 2005.

When another education collaboration in neighboring La Habra saw what the Fullerton collective was doing, Ross assumed a leadership role there, and it also grew to become a 501(c)(3), but not until 2015. He does similar work in two other targeted cities, though not yet to the 501(c)(3) level, and he works with a regional organization called Alliance for a Healthy Orange County.

The hospital shares insight from its needs assessment to help get support for some of its priorities, Ross said. "We just present data and say, 'These are some of our priorities, is there any resonance?'"

If so, discussion ensues about how community and hospital can take on initiatives together.

"We're more than just an interested party," he said. "We are an organization that's willing to provide leadership, provide technical assistance and also to provide some funding."

Collaboratives have their own strategic planning processes, and where there was a fit between the hospital and collaborative priorities, Ross helped shape the effort to identify groups with an interest or competency to participate. In Fullerton, for example, the not-for-profit collaborative adopted a priority around obesity prevention, also one of the hospital's high priorities, and formed a work group called Move More Eat Healthy. St. Joseph Health was a big part of the undertaking, but, importantly, the school district, the city and some nonprofits were deeply involved in developing a work plan and performance metrics.

Among the obesity prevention objectives completed or in process: 14 fitness centers in low-income neighborhoods, and grants to build such city amenities as a bicycle boulevard, more park space and other fitness-minded infrastructure; pushes by the school district for more intense physical education, better school nutrition and stronger policies encouraging wellness generally; four "resident leadership academies" to train low-income residents in how to advocate for their community's needs and then to identify an issue to pursue that keeps people from becoming overweight or obese.

Another ambitious program involves reducing health problems among homeless people, in partnership with a community group called Pathways to Hope that provides housing for frequent users of medical services and works to get them into permanent housing. Two community-care navigators at St. Jude Medical Center anticipate and arrange for whatever help is available. The program is "connecting people to the services they need, reducing unnecessary hospital visits, and hopefully connecting people to permanent, supportive housing," Ross said.

CONFLUENCE OF PARTNERS

The initiative in Arizona to reduce medical complications of homelessness is a confluence of unique partners operating in parallel on the same goals. Circle the City, a "medical respite center" for homeless people, offers housing for patients discharged and needing therapy, but with no place to go. It provides for a period of safe and comfortable recuperation, and about 80 percent of patients eventually are placed in either a group home or back with willing family members, said Garganta.

Parsons Family Health Center embeds a patient navigator in the St. Joseph's emergency department as well as the inpatient setting, going to the bedside of anyone identified as homeless to connect that person to outside services. Besides Circle the City, destinations include Human Services Campus, which provides a centralized intake process and coordinated assessment for homeless adults; Lodestar Day Resource Center, which encourages people to end their homelessness and make positive, long-term life changes; and Community Bridges, operating behavioral health programs integrated with medical care.

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An initiative called Smooth Way Home helps newborns with multiple compromising issues make the transition from neonatal intensive care to home care. Close cooperation between St. Joseph's and community agencies such as Raising Special Kids and Feeding Matters resulted in revelations about the expertise and detail involved in caring for and raising children with disabilities.

"We believed we were the experts in certain areas, and very quickly realized our community partner was the expert," Garganta said. The hospital also found that some services done in the hospital weren't necessary and could be done in the community instead.

The objective of Project Independence and Empowerment is to take patients from St. Joseph's highly regarded Barrow Neurological Institute and connect them with services post-discharge that extend both the "warm embrace" and exceptional medical care they received while hospitalized, Garganta said. Working with the Arizona Spinal Cord Injury Association, the Brain Injury Alliance of Arizona and the Arizona Bridge to Independent Living, the initiative strives to work with the patients' families, give them hope, get

them active again to the best of their ability, and "give them their life back," Garganta explained. "It may not be the life they had before, but it's a new life, a different life."

PROBLEM RESOLUTION

Community collaboration can foster insights into problem resolution that link separate initiatives together to make them both stronger. In Billings, Montana, St. Vincent Healthcare, a ministry of SCL Health, had been working on programs in the areas of obesity prevention, nutrition and physical activity, and making some progress but not enough, said April Keippel, mission and community benefit manager. The hospital and two other institutions sharing community responsibilities under a long-standing memorandum of agreement called The Alliance decided to dig deeper and unearthed additional complicating factors.

"The relationship between adverse childhood experiences and trauma, and outcomes related to obesity, is pretty strong," Keippel asserted. The Alliance, which also includes Billings Clinic and the city/county health department, had been working collaboratively on mental health issues and worked the issue of trauma-generated behavioral stress into the obesity initiative.

One key additional partner has been the master's program in social work at Walla Walla University's campus in Billings, where student counselors staff a free clinic to serve targeted patients in efforts to resolve past trauma and reduce obesity risk. They serve clients without health insurance who otherwise would not have these needs met. Walla Walla had been challenged to provide sufficient clinical supervision hours for students to complete the graduate program, and the program's caseload helps the college supply enough of those hours, Keippel said.

Still another approach to reducing obesity takes a "supply side" angle, stocking and selling fresh produce from mobile vehicles that travel a regular circuit around city neighborhoods to improve nutrition by making the produce accessible and affordable. In Springfield, Massachusetts, the Go Fresh Mobile Market makes 13 stops from July through October, including in front of financial sponsor Mercy Medical Center. Farms in the rural areas outside Springfield are the suppliers, said Doreen Fadus, Mercy vice president of mission integration and community health/well-being. The markets are open to all, but people in the Supplemental Nutrition Assistance Program get a discount when they use their SNAP card.

Mercy invests in a range of other programs using grant money from Trinity Health of New England to support issues related to obesity and tobacco use. It floated a $180,000 low-interest loan to cover a shortfall in a $10 million project to operate a hydroponic greenhouse, a growing method that doesn't require planting in the ground. Mercy is a confirmed purchaser of lettuce from the project, as are the Springfield schools and a large local grocery chain, Fadus said.

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Trinity loan funds also are helping to get the Springfield Culinary and Nutrition Center off the ground, a food-processing partnership of Springfield schools and its cafeteria contractor Sodexo. The school district's 30,000 students currently get their lunch items from a food processing plant in Rhode Island because there is no such facility in the Springfield area. When the local plant opens in November 2018, the ability to process locally grown food will circumvent that long supply route and improve food quality, said Fadus. Additionally, the center will generate 40 to 50 jobs and a training program for district students.

UNDERSERVED ADOLESCENTS

Nutrition is part of the bigger issue of adolescent health, and adolescents are the most underrepresented patient demographic, said Coletta Barrett, RN, vice president of mission for Our Lady of the Lake Medical Center, Baton Rouge, Louisi-

ana. With the increase in diabetes among schoolchildren, such services as insulin dosing and monitoring are on the rise. Barrett says a body of research into access to care showed that children are underserved because they rely on others to get them to services.

"Well, we know that adolescents go to school, so maybe we need to start looking at providing health care in schools," Barrett said.

Baton Rouge schools had been served by a not-for-profit 501(c)(3) organization called Health Centers in Schools for nearly 30 years, but the increase in care intensity and the costs of operation began overwhelming the agency, so it became a wholly owned subsidiary of Our Lady of the Lake five years ago. In return for providing legal, human resources, risk management and other support services, the hospital system gained access to 43,000 students at centers similar to pediatrician offices in seven middle and high schools.

The integrated medical model includes mental health, placing social workers and psychologists in the health centers and rotating through nurses' offices in all 84 public schools in Baton Rouge. Integration extends to information sharing and communication between clinicians in the centers and pediatric specialists credentialed at Our Lake of the Lake Children's Hospital. All are connected to and using the same clinical information technology platform.

Chronic diseases such as asthma are on the radar, not just in schools but when children go home at night, Barrett said. Five years ago, several community groups including Southeast Louisiana Legal Services, the Baton Rouge Bar Association and Franciscan Missionaries of Our Lady Health System created the state's first medical/legal partnership, known as Capital Area MedLAW Partnership. The health system, to which Our Lady of the Lake belongs, provided funding for the partnership's first objective: to bring free legal services to bear in the area of uncontrolled asthma. That includes writing letters to landlords to fix asthma-inducing problems.

"We have a unique opportunity to leverage our resources to do things to help," Barrett said. "We could use our position of power to help influence other things to happen, and we don't have to be the ones to necessarily have to do it."

JOHN MORRISSEY is a freelance writer specializing in health care delivery, policy and performance measurement. He lives in Mount Prospect, Illinois.

NOTES

1. Lawrence Prybil et al., "Improving Community Health through Hospital-Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships," *Health Management and Policy Faculty Book Gallery* 2 (2014). https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1001&context=hsm_book.

2. Glen P. Mays, Cezar B. Mamaril and Lava R. Timsina, "Preventable Death Rates Fell Where Communities Expanded Population Health Activities through Multisector Networks," *Health Affairs* website (Nov. 1, 2016). www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0848.

3. Glen P. Mays and Cezar B. Mamaril, "Public Health Spending and Medicare Resource Use: A Longitudinal Analysis of U.S. Communities," *Health Services Research* 52, no. 6.1 (December 2017). www.hsr.org/hsr/abstract.jsp?aid=52793641998.

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