Improving Community Health through Multi-Sector Partnerships

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A common goal in the mission statements and strategic plans of many non-profit, tax-exempt hospitals and health systems in the United States is to improve the health status of the communities they serve.

Yet, until recently, the board's role in this area has been unclear and there was a dearth of evidence to demonstrate how hospitals and health systems were fulfilling this responsibility. A recent study involving hospital–public health collaborations to improve community health provides guidance to hospital and health system boards.

While hospitals and health systems were faithfully fulfilling the Internal Revenue Service (IRS) "community benefit" requirements, it was difficult to show how their community benefit programs and activities had made a positive improvement on the health status of the community.

Further, there has been lack of clear understanding on several key terms and concepts in this area, including how to differentiate "health" and "healthcare" in this new dialogue; how "community health status" or "population health" was being defined; how the "community" was defined in an era of rapid health system consolidation; what forms of collaboration had proved successful in improving the health status of a community; what metrics are relevant in measuring improvement; and how health improvement activities can be organized and operated in a sustainable financial model.

The ACA upped the ante in this area in two significant ways:

- All tax-exempt hospitals are required to conduct community health needs assessments (CHNAs) at least every three years, with input from persons who represent the broad interests of the community; develop an implementation strategy to address priority needs; and make them widely available to the public.
- The National Strategy for Quality Improvement in Health Care,[1] required by the ACA, developed by the Secretary of HHS, and published in March 2011, established three aims for quality improvement, one of which is to improve the health of the population (i.e., population health).[2]

These developments have placed a new emphasis and regulatory scrutiny on community health needs and what measures should be taken to improve the health of the population. Faced with these issues, board members are called to provide strong governance leadership. Several action items should be considered by senior leadership and boards of hospitals and health systems:

- Clarify the board's responsibilities in the area of community health and how the board monitors fulfillment of its responsibilities.
- Develop annual board goals to address community health improvement.
- Provide clear differentiation between the hospital's traditional obligation to provide "community benefit" and the newer requirements regarding "community/population health."

1 *2011 Report to Congress: National Strategy for Quality Improvement in Health Care,* U.S. Department of Health and Human Services (available at www.ahrq.gov/workingforquality/reports/annual-reports/nqs2011annlrpt.htm).

2 The National Strategy for Quality Improvement in Health Care established three aims (and six priorities) for quality improvement: 1) better care: improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe; 2) healthy people/healthy communities: improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants for health in addition to delivering higher-quality care; and 3) affordable care: reduce the cost of quality care for individuals, families, employers, and government (also known as the Triple Aim).

Key Board Takeaways

In many hospitals and health systems, the board's role and responsibility in the area of improving community health is unclear and there is little evidence as to how improvement is being measured and monitored. With increased emphasis and scrutiny on community health needs, board members are called to provide strong governance leadership. A recent study on improving community health through hospital–public health collaboration provides board members with several key takeaways:

- Clarify the board's responsibilities regarding community benefit and community health improvement.
- Establish a standing board committee to provide oversight and monitor performance.
- Collaborate with key stakeholders in the community, including public health, health plans, employers, and competing hospitals.
- Link community health initiatives to the community health needs assessment.
- Evaluate performance with specific objectives, targets, and metrics.
- Develop objective value propositions that demonstrate benefits to the community.
- Develop long-term sustainable funding strategies.

- Undertake board education on the regulatory requirements and expectations in this area.
- Evaluate the collective competencies of the board to make certain that it has the right people in the boardroom to address this new challenge.
- In identifying and prioritizing the health needs of the community, consider collaborating with other partners, including competing hospitals, in a community-wide effort.
- Provide strategic input on the priority health needs of the community, what initiatives should be implemented, and a realistic timeline and milestones to monitor improvement.
- Strategize on sustainable funding sources.
- Provide insight on, and approval of, the metrics to be used to monitor and measure community health improvement.
- Promote transparency and communication with the community and key stakeholders.

ACA-driven developments have placed a new emphasis and regulatory scrutiny on community health needs and what measures should be taken to improve the health of the population.

Improving Community Health through Hospital–Public Health Collaboration

Confronted with these emerging issues, a study was recently conducted by the Commonwealth Center for Governance Studies with the purpose of identifying and examining successful partnerships involving hospitals, public health departments, and other population health stakeholders. The purpose was to ascertain key lessons learned from their collective experience and offer recommendations based on the data and analyses. With funding from Grant Thornton LLP, Hospira, Inc., and the Robert Wood Johnson Foundation, the study's key findings, lessons learned, and recommendations were published in November 2014. The data, key findings, emerging patterns, and recommendations cited herein

are based on that report.[3] The observations and insights reflect the views of the authors based on their extensive work and experience with hospital and health system boards.

After developing a set of core characteristics of successful partnerships involving hospitals, public health departments, and other parties,[4] the researchers invited and received nominations of 157 partnerships located in 44 states.[5] The partnerships were screened against the core characteristics and subsequently reduced from 157 to 12 exemplary and diverse partnerships. The 12 partnerships represented 11 states and varied in geography from coast to coast, rural and urban, state-wide or local community, and in scope from a broad focus ("to be the healthiest community in the nation by 2020," Healthy Monadnock 2020) to a narrow focus ("reducing the infant mortality rates in three inner-city neighborhoods," Detroit Regional Infant Mortality Reduction partnership). (See sidebar "Partnerships Involved in the Study" for a full list of participants.) The research team conducted two-day site visits and completed interviews of key partnership representatives, board members, and senior leadership.

3 L. Prybil, D. Scutchfield, R. Killian et al., *Improving Community Health through Hospital–Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships,* Commonwealth Center for Governance Studies, Inc., November 2014 (available at www.uky.edu/publichealth/hospital/collaboration).
4 *Ibid.,* pp. 48–49.
5 *Ibid.,* pp. 51–62.

Partnerships Involved in the Study

The study on improving community health through hospital–public health collaboration included 12 diverse partnerships from across the U.S.:

- National Community Health Initiatives, Kaiser Foundation Hospitals and Health Plan, Oakland, California
- California Healthier Living Coalition, Sacramento, California
- St. Johns County Health Leadership Council, St. Augustine, Florida
- Quad City Health Initiative, Quad Cities, Iowa-Illinois
- Fit NOLA Partnership, New Orleans, Louisiana
- HOMEtowns Partnership, MaineHealth, Portland, Maine
- Healthy Montgomery, Rockville, Maryland
- Detroit Regional Infant Mortality Reduction Task Force, Detroit, Michigan
- Hearts Beat Back: The Heart of New Ulm Project, New Ulm, Minnesota
- Healthy Monadnock 2020, Keene, New Hampshire
- Healthy Cabarrus, Kannapolis, North Carolina
- Transforming the Health of South Seattle and South King County, Seattle, Washington

Emerging Patterns

Each of the 12 partnerships that participated in the study is unique in several respects. While all were dedicated to improving the health of the communities they serve, their origin, mission, goals, and their strategies for addressing health needs varied considerably. Yet, certain patterns appeared consistently in all 12 partnerships.

A Focus on Population Health

Increasing focus at the local, state, and national levels on "population health" and improving the health of the communities was at the core of these partnerships. There is a fundamental change occurring in the United States driven by the awareness that inadequate attention and resources have been allocated to prevention of illness and injuries, early diagnosis and treatment, and promotion of wellness. Further, hospitals are now being held accountable for healthcare outcomes through various programs including accountable care organizations (ACOs), value-based purchasing (VBP), pay-for-performance, bundled payments, and never events. These transformational changes require community health considerations, not just individual patient concerns or a focus only on patients in the hospital. It also needs a community orientation with new partnerships and relationships with others and the pulling together of several community resources to develop that shared and collective capacity.

Mission Statements

All of the partnerships' mission statements focus on improving the health of the community they serve, but the nature and scope of the respective missions of the 12 partnerships varied significantly ranging from a narrow to a very expansive scope. One of the problems noted in several partnerships was that it was difficult to fulfill the mission where it was not evident that the hospital, public health department, and other partners had a clear and common understanding of what "community health" or "population health" means, the geographic scope of the community served, how health status should be measured, and/or the evidence-based targets for improvement.

Partner Engagement

The active engagement of many partners in the establishment and ongoing operations is essential to the partnership's sustainability and success. The principal partners in the 12 partnerships universally included a public health agency or agencies and one or more hospitals or health systems. A welcome pattern found in several of the partnerships was that competing hospitals in the community collaborated together in addressing the need to improve the health of the communities they served. On the other hand, while the improvement of community health should be of equal

concern and focus to local businesses and health plans, the common pattern of the partnerships studied showed very few local businesses or health plans as partners.

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Difficulty Measuring Progress on Objectives and Metrics

Many partnerships continue to be challenged in developing objectives and metrics and demonstrating their linkages with the overall measures of population health on which they have chosen to focus. Most of the partnerships studied are challenged to set, articulate, and prioritize goals, objectives, and metrics that clearly reflect the mission, and to measure and monitor progress in a way that demonstrates improvement and maintains the momentum of the partners. This can be problematic for hospital boards and leaders who are accustomed to evaluating financial, strategic, and quality performance through the routine use of metrics, goals, and scorecards.

Starting with a Loose Affiliation Model

A large majority of the partnerships studied are organized in a loose affiliation or coalition model. While a majority of the partnerships were formed in a loose organizational model with a policy-setting body, none were organized in a corporate model, nor have evolved into a more structured organizational model. Several of the interviewees made it clear that going to a formal structure in the beginning would most likely not have been well-received in the community. Yet, a substantial proportion (one-third) of leaders interviewed believe their organizational model needs to evolve to a more structured form.

Financial Sustainability Challenges

Financial sustainability remains a significant challenge in most partnerships. With few exceptions, the partnerships studied were created without long-term sources of financial support. They tend to be lightly funded and therefore must constantly seek external grant support. The leanest partnership operated with total financial support of just over $60,000 for its most recent fiscal year, while the most highly capitalized partnership received an average of $4.6 million per year in financial support over its 10-year history. In addition to anchor institutions such as hospitals, health systems, and public health departments, other long-term sources of financial support could include health plans that understand the need and benefit of focusing more resources on population health, and local employers that see the value proposition to the community, their employees, and local government.

Recommendations

The research team concluded that partnerships involving hospitals and/or health systems, public health departments, and other key stakeholders in the community have an important social role and can serve as effective vehicles for collective action focused on population health improvement. Based on empirical findings and our judgment, the study team developed 11 recommendations,[6] the following 10 of which should be of special interest to hospital and health system board members and senior leaders.

1. Partners

Partnerships should include hospitals and public health departments as core partners and, over time, these core partners should reach out and engage a broad range of other parties from the private and public sectors. Other potential partners include school

6 Prybil, Scutchfield, Killian, 2014, pp. 39–44.

systems, health plans, local government, business organizations, and community interest groups. It has become clear that hospitals and public health departments are logical and essential partners in efforts to improve the health of the communities they serve. Hospitals that compete in other ways can find common ground to collaborate in this important work. For example, in the Quad City Health Initiative, Genesis Health System and UnityPoint Health-Trinity are anchor institutions that provide financial support, serve on the board of the partnership, and are committed to its goals and objectives, yet they compete aggressively in the same region on healthcare services. Collaborating with local hospitals and health system can have many benefits, such as helping to align community health initiatives, making efficient use of resources, leveraging the expertise of partners, sharing health data, and avoiding duplication of efforts. In support of this conclusion, the final CHNA regulations promulgated by the IRS effective December 29, 2014, strongly emphasize the value of collaboration and encourage and facilitate collaboration with other hospitals and organizations for the common good of the community.

2. Trust-Based Relationships
Whenever possible, partnerships should be built on a foundation of pre-existing, trust-based relationships among the founding partners. Indicators of a strong culture among partners include a tradition of participating in collaborative arrangements, mutual respect and trust, and being open and transparent with one another. It is not necessary or feasible for independent organizations or competing hospitals that establish or join a new partnership to have identical values or cultures, but without substantial congruence, problems are likely to occur. For long-term success, all partnerships require sustained attention to building and maintaining relationships among principal partners based on honesty, mutual respect, and trust.

While there is growing attention to "population health" in all sectors, there is not broad understanding—even among health professionals—regarding definitions, priorities, or the metrics that should be used in assessing community health and measuring progress in improving it.

3. Mission and Goals
Partnerships should adopt a statement of mission and goals that focuses on clearly defined, high-priority needs and will inspire community-wide interest, engagement, and support. The mission and goals need to be defined both strategically and pragmatically and balance many factors including prioritization of community needs, existing programs and services, current and potential sources of funding, and the pros and cons of using a collaborative partnership as a vehicle vis-à-vis other organizational models. The statement should also carefully define the scope and nature of the mission and goals in a realistic framework that will translate into a tangible plan of action. A partnership with a mission that is unrealistically broad and complex is likely to experience difficulty in demonstrating sufficient progress to generate sustainable funding and maintain community interest.

4. Anchor Institutions
Partnerships need to have one or more "anchor institutions." While many partnerships were established by a small number of organizations that share common interests, it is clear that the long-term survival and success of these partnerships is enhanced when one or more principal partners step forward to serve as an "anchor institution." Partnerships without an anchor institution to provide a solid, dependable foundation of economic and non-economic support are inherently fragile and constantly dependent upon obtaining new sources of financial support to sustain core operations.

5. Organizational Structure
Partnerships should have a designated body with a clearly defined charter that is empowered to set policy and provide strategic leadership. Though structure is important, collaborative parties do not need a formal corporate structure to achieve the goals and objectives of the participants. While a majority of the partnerships studied are organized in a loose affiliation or coalition model, it remains prudent for the principal partners to create a mechanism for shaping the partnership's operating policies, providing strategic leadership, and making budgetary and resource allocation decisions. These bodies can take on various names such as a board, steering committee, or leadership council. Whatever term is employed, it is important to clearly define the role and accountability of the body and this can be done in a written charter or other organizational document.

6. Population Health Terms, Concepts, and Principles
Partnership leaders should build a clear, mutual understanding of "population health" concepts, definitions, and principles among the partners, participants, and community at large. While there is growing attention to "population health" in all sectors, there is not broad understanding—even among health professionals—regarding definitions, priorities, or the metrics that should be used in assessing community health

and measuring progress in improving it.[7] Partnership leaders should intentionally devote efforts to build a solid base of common understanding regarding important population health concepts, definitions, and principles.

7. Evaluating Performance

To enable objective, evidence-based evaluation of a partnership's progress in improving the health of the community, leadership must specify the community health measures to be addressed, the specific objectives and targets they intend to achieve, and the metrics and tools they will use to track and monitor progress. Selecting the objectives and targets they want to achieve and the appropriate metrics to monitor progress are among the most important and challenging duties of the leadership team. Unless these selections are based on the best science currently available, it is difficult, if not impossible, to evaluate the success of the partnership's programs and strategies. One example of the methods employed to develop measures is found in the Healthy Montgomery[8] partnership where population health is seen as a shared responsibility of healthcare providers, governmental public health agencies, and many other community institutions. To manage this shared responsibility, two sets of measures were developed: 1) a community health profile that summarizes a community's overall health status for which all parties share responsibility, and 2) a set of measures that focus on performance of agreed-on program activities.[9]

> Making demonstrable improvement on key measures of community health is difficult and requires a long-term commitment of efforts and resources. This reality needs to be communicated and understood by the key stakeholders.

8. Value Proposition

Partnerships should develop and disseminate "impact statements" that present an evidence-based picture of the effects the partnership's efforts are having in relation to the direct and indirect costs it is incurring. The intent of the impact statements is to provide partners, funders, key stakeholders, and the community at large with an objective "value proposition" that demonstrates the benefits to the community in relation to its operating and capital costs. Making demonstrable improvement on key measures of community health is difficult and requires a long-term commitment of efforts and resources. This reality needs to be communicated and understood by the key stakeholders. Much of this work is in the early stages, and it became clear in the study that it is extremely difficult to "bend the curve" on key community health indicators. As discussed more thoroughly in the report, the health of a community or population group is determined by a complex array of factors, many of which are outside the control of the hospital, health system, or public health agency.

9. Sustainable Funding

Partnerships focused on community health improvement need to develop a deliberate strategy for broadening and diversifying sources of funding support. A major challenge for most of the partnerships in the study was securing sufficient and sustainable funding. Partnerships with anchor institutions (hospitals, health systems, and public health departments) have a stronger and more durable foundation; e.g., Kaiser Foundation Hospitals and Health Plan is the home base for Kaiser's system-wide Community Health Initiatives program; MaineHealth, a Portland-based non-profit health system, is the principal sponsor for HOMEtowns Partnership; and the St. Johns County Health Leadership Council in Florida and Healthy Montgomery partnership in Maryland (and other partnerships) are closely aligned with strong local health

7 U.S. Centers for Disease Control and Prevention, *Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants,* Atlanta, GA: Office of Surveillance, Epidemiology, and Laboratory Services, 2013; Institute of Medicine, *Vital Signs: Core Metrics for Health and Health Care Progress,* Washington, D.C.: The National Academies Press, 2015.

8 The product of a community health needs assessment, Healthy Montgomery in Rockville, MD, includes all five area hospitals, safety net clinics, minority health initiatives, and social services agencies in a formal consortium of interested parties dedicated to health improvement; see Prybil, Scutchfield, Killian, 2014, pp. 76–77.

9 See Healthy Montgomery Core Measures, *Ibid.,* pp. 78–79; Michael A. Stoto and Colleen Ryan Smith, *Community Health Needs Assessments—Aligning the Interests of Public Health and the Health Care Delivery System to Improve Population Health,* Institute of Medicine, April 2015 (available at http://bit.ly/1RzAkHO).

departments. Subsequent to completion of our study, Blue Shield of California has begun providing financial and other forms of support for the California Healthier Living Coalition, one of the partnerships in the study. Both local employers and health plans that provide coverage for population groups served by successful partnerships focused on community health improvement will benefit from the partnership's efforts. We believe it is time for successful partnerships to "make the case" both to major employers and health plans. Well-documented, evidence-based impact statements, including the value proposition and/or the ROI, are likely to be essential in securing their interest, understanding, and support.

10. Standing Board-Level Committee
Governing boards of hospitals, health systems, and local health departments should establish standing community benefit committees to provide oversight of their responsibility to improve the health of the community. Hospital and health system boards that have oversight responsibility for improving the health of the community should establish a standing committee of the board and charge it with the responsibility for the organization's role, priorities, and performance in the realm of population health improvement, including their strategies for promoting collaboration with other community organizations. The existence of a standing board committee composed of persons with special interest and expertise in population health will focus board attention on important issues and galvanize ongoing action and evaluation of progress.

Conclusion

Several years ago, we were attending a board retreat of a large non-profit health system when during a review of the health system's mission statement ("to improve the health of the communities we serve"), one of the board members asked the question, "What business are we in, 'health' or 'healthcare'?" It was clear in the ensuing discussion that our core business was "healthcare"—treating illness and disease whereas "health" entailed preventing persons from getting sick or ill. The whole discussion stimulated us and has caused us to question what a hospital means when its mission statement refers to improving the health of the community. We think what it means to most hospitals is that they will provide low-cost and high-quality healthcare to the patients they serve. Through their community benefit requirements, they will provide uncompensated care as well as other programs that will benefit the community such as research, education, increased access, new patient care services, etc.

Now, the business of "health" is the new frontier. While hospitals and health systems need to maintain and sustain the core business of healthcare, who better to take a leadership role in the effort to improve the health of the communities than healthcare providers and public health agencies. And while no single hospital or health system can be accountable for the overall health of the community, who better to set and help direct the culture of health tone than hospital and health system leadership and boards.

The Governance Institute thanks Rex P. Killian, J.D., President of Killian & Associates, LLC, and Lawrence Prybil, Ph.D., LFACHE, Norton Professor in Healthcare Leadership and Associate Dean, College of Public Health, at the University of Kentucky, for contributing this article. They can be reached at rkillian@killianadvisory.com and lpr224@uky.edu.