CEO INSIGHT SERIES

The Importance of Community Partnerships

American Hospital Association

community CONNECTIONS

American Hospital Association

Photos in this publication are courtesy of the featured hospitals.

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COMMUNITY CONNECTIONS OVERVIEW

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

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

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

Community Connections is a long-term initiative of the American Hospital Association (AHA) aimed at helping hospitals across America reaffirm their rightful place as valued and vital community resources that merit broad public support. It is the hope of the AHA that the concept of Community Connections will be an anchoring theme as hospitals formulate their own effective strategies for listening, communicating and collaborating with their communities.

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

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

COMMUNITY PARTNERSHIPS OVERVIEW

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

Ultimately, the new law, the Patient Protection and Affordable Care Act (PPACA), reflected many of the key principles in AHA's *Health for Life* framework, including advancing wellness and prevention efforts as well as improving efficient, affordable care through care coordination. As implementation of the new law moves forward, the AHA will continue to provide support and assistance to hospitals to advance these principles and, thus, to advance a delivery system that improves health and health care for all. The CEO Insight Series is intended to provide examples and lessons learned from hospitals and health systems that have successfully collaborated with local organizations to promote health within their communities.

This CEO Insight Series resource focuses on partnerships that promote coordination of care, as well as wellness and prevention. Health care organizations from across the country were interviewed on collaborations that successfully leverage resources and efforts while addressing broader community health concerns. This kind of collaboration has the potential to more effectively achieve any number of goals, including: increasing access and coordination of care; reducing duplicative efforts and services; filling gaps in services; empowering patients to better manage their health; and promoting healthier lifestyles.

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

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

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

PARTNERING
ON CARE COORDINATION

PARTNERING ON CARE COORDINATION
EXECUTIVE SUMMARY

Impetus for Programs

The coordination-of-care case examples included in this CEO Insight Series represent a broad range of efforts, from small, grant-funded community collaborations to large-scale comprehensive health networks. Despite differences, key themes consistently center around goals of increasing coordination of care, broadening access to care and reducing redundancies in the system. Each program was developed in response to an identified community need, two of the most common being the need for medical homes and lack of care coordination within the community.

- **Creating medical homes.** Many of the communities in these case examples were experiencing increasing numbers of patients coming to the emergency department (ED) for care that should have been provided by a primary care physician. Not only was this contributing to hospitals' growing challenge of over-crowded EDs, but it was inhibiting patients' ability to get the care they really needed. With a goal of helping uninsured and underinsured patients access consistent, coordinated care, many hospitals are working with their community partners to create a medical home that provides the initial and follow-up care patients need in the most appropriate setting. Some medical home programs include full-time coordinators that help patients navigate the system and ensure they are connected with the right services and providers. These coordinators help in a number of ways, including making appointments, leveraging provider agreements to ensure affordability for patients, helping patients with transportation and ensuring patient medical records are appropriately transferred. One of the most comprehensive medical home case examples included a team-based structure that spanned the organization and provided needed support for physicians by assuming some of the work and responsibility for care coordination and delivery previously shouldered solely by physicians.
- **Increasing coordination and awareness of existing services.** In addition to inconsistencies in receiving care in the most appropriate setting, lack of care coordination is an ongoing challenge in most American communities. Many organizations report that lack of awareness about local services and resources causes patients and family members to miss out on programs that would benefit them, while others receive duplicative care. By bringing various community organizations together, hospitals and their partners are able to provide more comprehensive information about available resources and services to patients and their family members. The collaboration unites key players around shared goals and a shared vision for a better community. In turn, this facilitates pooling existing resources to maximize benefit, streamlining services to reduce or eliminate duplication and as needed, the expansion or development of new programs to meet community needs.
- **Responding to unique community health needs.** While many of the organizations' care coordination efforts focus on overall coordination and collaboration and accessing the health care system, some focus on uniquely identified needs specific to local communities.
- **Meeting community need through broad partnerships.** While the partnerships are generally initiated by the hospital or health system, once they are established some continue to be led by the hospitals while others represent equal leadership among all participating organizations. Partners vary depending on locality and scope of the initiative, but include other local health care providers, community health centers and private medical practices, social service organizations, schools, social workers, law enforcement agencies, government agencies, local and regional non-profit organizations and many other community groups.

  In addition to partnering with community organizations, some care coordination initiatives involve partnerships among hospitals. While participating hospitals may be market competitors, they are simultaneously collaborative in delivering non-competitive services important to the community. For example, all hospitals have a shared interest in helping patients with a need for case management and assisting them in getting the right care in the right setting.

> Our Center for Community Health initiative has been successful because of the great commitment we have from our community partners.
>
> Doreen Krabbenhoft, Development Director, Elmore Medical Center

Mission and Hospital Role

- **Hospitals and health systems provide leadership, financial support and other needed resources.** In most communities, hospitals are the entity with the needed influence to rally key community leaders around the development of a collaborative network or partnership. But hospitals' involvement often moves well beyond bringing all the key players to the table. In many cases, hospitals provide leadership support, operational oversight, financial support, in-kind donations and resources, as well as dedicated staff to ensure that the care coordination efforts are successful. In some cases, the efforts are so extensive that multiple hospital employees are dedicated to the initiative, ensuring that patients are directed to the right place, receive the follow-up care they need or are involved in a medical home.

- **Hospital and health system leaders and boards of trustees are involved.** Hospital and health system leaders and boards of trustees are consistently involved in fostering community partnerships that facilitate coordination of care. Often a member of the hospital's senior leadership team is directly involved in the effort's activities and decision-making, and regular progress reports are presented either to a board sub-committee or to the full board. In many cases, the program includes regular review and approval by the board for new projects and continued funding. When initiatives involve a separate organizational board or advisory committee, members of the hospital's senior leadership team and board often serve on the program's board or committees in addition to their regular hospital commitments.

> The medical home model of care is stimulating in its evolution. This team-focused, patient-centered care has many important components to it – guiding the patient through the continuum of care, whether it be with chronic disease, acute illness or prevention.
>
> Betsy Cotter, RN,
> Cheshire Medical Center/Dartmouth-Hitchcock Keene

Measuring and Communicating Success

Perhaps the most meaningful measures of a program's success can be found in the anecdotal stories told by patients served, but anecdotes alone are not enough to demonstrate a program's true significance and influence. The programs featured in this CEO Insight Series used measurable indicators to track their progress and success.

- **Pre-determined measurements of success.** The measures used to evaluate the success or improvement a program achieves depend on the type of program considered. Organizations with collaborative programs that focused on providing a medical home or comprehensive, coordinated care delivery systems often track pre-determined measurements of success, such as the number of people with health care coverage, dollars of pharmaceutical assistance provided, the number of people enrolled in educational or mentoring programs, increased area capacity for primary care services, wait times and "no show" rates for appointments and the number of repeat emergency department visits.

  Collaborative efforts targeting specific community health needs track individual health indicators, such as obesity rates, smoking cessation statistics and rates of chronic diseases or hospital admissions for chronic diseases.

- **"Side effects" include increased employee satisfaction and new ways of thinking.** In addition to these regularly reviewed "vital statistics," many of the participating hospitals have experienced positive outcomes that are more difficult to measure, including increased employee satisfaction, innovations in addressing health problems and collaboration to better meet patient needs. Employees report that they are more effectively meeting patient needs, and several hospitals report a significant increase in employee participation at volunteer events as employees become personally committed to the collaboration and its impact on the community.
- **Strengthened public trust and support for hospitals and health systems.** Enhanced coordination of care and collaboration in the community have strengthened hospitals' community reputations and garnered a new level of public trust for many hospitals and health systems. In addition, multiple organizations have received local, state and national recognition for their coordination of care efforts, including publication in national medical journals, state business and workplace awards and achieving Magnet status.
- **Better patient care, improved quality of life and increased cost savings.** Through preventive care and supportive resources as well as better coordination of care, patients are able to remain in their own homes or other appropriate care environments, and hospitals are better able to manage their capacity effectively. Although the primary goal of their collaborative efforts is to better meet patient needs, ensuring that patients receive the education, resources and medical care they need in the right location at the right time also has helped hospitals reduce costs.

Funding and Sustainability

Each collaborative program is unique to the community it serves, and so is its funding. While some communities rely heavily on grant funding, others rely on financial contributions and in-kind donations from all participating partners.

- **Hospitals generally take the financial lead.** Many of the initiatives began with external grant funding, and transitioned to funding ongoing operations through more consistent sources. While most collaborative efforts combine a variety of support and funding sources, hospitals and health systems almost always take the lead in ensuring financial sustainability, whether it is by providing internal funding, writing grant applications, coordinating fundraisers or obtaining in-kind support.

  Nearly all hospitals represented in the case examples supply critical financial support for the programs, either through the hospital's annual operating budget or via a one-time donation. In addition, many hospitals fund full-time staff positions dedicated to coordination of care initiatives.

- **Community fundraising efforts raise money and community support.** Depending on the availability of resources and the scope of the initiative, some programs also are supported by community fundraising efforts. One hospital's annual chili cook-off raised more than $15,000, not only fulfilling a necessary financial need but also demonstrating the community's commitment to the organization's efforts. Community fundraising efforts can serve as an actionable way to keep the community involved and invested in the program.
- **Pilot programs bring new financial opportunities.** One organization's success in raising quality of care and delivering cost savings made them eligible for a financial bonus under a Centers for Medicare & Medicaid Services Pay for Performance demonstration project. Opportunities to participate in pilot and/or demonstration programs with financial incentives may increase as new programs become available for accountable care organizations under the PPACA.
- **Many programs generate cost savings for hospitals.** Although significant investment costs are associated with some of the coordination of care initiatives, several hospitals report that they have saved close to, or more than, their investment in the program by preventing unnecessary care and/or directing patients to more appropriate care locations. The financial impact of care coordination is much more complex than simply measuring dollars in and out. Other financial benefits for hospitals and their partners include reduced ED visits and inpatient stays, avoided costs of facility expansion and equipment purchases and, of course, the benefits associated with providing services that more effectively help improve the health and well-being of patients and the community served.

Advice to Others

Representatives from the programs featured in the case examples offer advice about collaboration, leadership and planning, information technology and capitalizing on new opportunities.

- **Collaboration achieves more than any hospital can do independently.** Hospitals participating in coordination of care initiatives agree that partnering with a wide variety of community organizations is absolutely essential to success. Community-wide collaborations allow hospitals to implement comprehensive approaches that meet patients' holistic needs, and help hospitals achieve better community health outcomes and improved access to care than could be achieved by hospitals alone. Each community partner has a unique and valuable role in the partnership, whether it is offering services, providing leadership support or in-kind donations, or ensuring that those in need of the program or initiative are made aware of the services available. Because hospitals are often natural leaders in their communities, they have a unique opportunity to facilitate these partnerships and bring all of the key players together around a shared goal.
- **Physician and other provider involvement and buy-in are critical.** Strong physician/hospital alignment is important. Without it, establishing a medical home and effectively coordinating care is difficult to achieve. In addition, it is important to remember that care coordination does not just include primary care providers—it should extend to physician specialists; specialty providers, such as post-acute care, home care and behavioral health providers; and clinics in schools and workplaces.
- **Care coordination is an opportunity to better position the hospital and community for the health care system of the future, and reap the benefits now.** Greater collaboration and a community-wide infrastructure are highly valued elements in transitioning to a more effective and efficient health system. It is clear that coordinated care efforts such as the medical home concept will position hospitals to provide better care to their communities, prepare hospitals and other health care providers for new reimbursement approaches and will position providers to better respond to both emerging regulations and new patient demands.
- **Information technology improves quality of care, provides more integrated coordination and helps track program success.** Many of the organizations undertaking community-wide coordination of care efforts use information technology systems that allow the participating organizations to share information electronically. Not only does this enhance the quality of care provided to patients and help organizations move toward more seamless care, it also helps organizations comply with new health information technology requirements. Equally important, a comprehensive information technology system allows hospitals and their partners to measure results and track pre-determined measures, providing the information needed to evaluate the effectiveness of programs and proactively make improvements aimed at improving community health.

> The Community Case Management program extends a health care organization's focus beyond the walls of the inpatient facility. It places resources in an area that improves the overall health and well-being of individuals and family members struggling with chronic physical and mental needs. Most importantly, the care provided is in an environment that is appropriate and comfortable at a much lesser cost.
>
> Craig Luzinski, Chief Nursing Officer
> Poudre Valley Hospital

BON SECOURS DEPAUL MEDICAL CENTER – Norfolk, VA

Program: Life Coach Model of Care

Impetus for Program

To help patients that were visiting the ED at regular intervals for care that should have been provided by a primary care physician, Bon Secours DePaul Medical Center developed a Life Coach Model of Care program. The program connects uninsured and underinsured patients with consistent, coordinated medical care including comprehensive services, follow-up care, patient education, access to social services and a medical home at a federally funded clinic.

Mission and Hospital Role

The Life Coach Model of Care program was driven by Bon Secours' mission to care for the poor – not only when they walk in the door, but to provide comprehensive, holistic care.

Developed by the hospital's Vice President of Mission, the program's operations fall under the leadership and supervision of the Emergency Room Vice President. The medical center pays the salaries for the Life Coaches, and although the clinic is federally funded, the hospital provides additional funding to allow the clinic to extend its hours.

Measuring and Communicating Success

Program patients report improved health and quality of life. It provides peace of mind to patients who previously had no medical home, with a personal doctor they can call to ask questions, renew prescriptions, or make an appointment with rather than going to the ED for non-emergency-related care. The program's success is communicated through regular updates with area hospitals and organizations.

Funding and Sustainability

Initial start-up costs for the program were about $5,000 and ongoing operations total $85,000 annually. The hospital estimates roughly $200,000 in savings last year from program patients who no longer use the ED for their non-emergency care.

Advice to Others

Developing community partnerships is essential to a successful Life Coach approach. While the concept can be implemented in-house, partnering with a community agency provides a comprehensive approach.

A successful program requires a well-organized, well-run clinic to which one can refer patients. The hospital must work closely with the clinic to problem-solve issues such as how appointments will be scheduled and what to do if the clinic reaches capacity.

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CARROLL HOSPITAL CENTER – Westminster, MD

Program: Access Carroll

Impetus for Program

After a community needs assessment identified the lack of access to health care as a priority, the Carroll County Board of Health and the Board of Carroll Hospital Center partnered to work collaboratively and improve the health of residents. The Partnership for a Healthier Community grew and became a not-for-profit organization devoted to community health improvement. A direct result was Access Carroll, a clinic that provides free health care to uninsured, low-income county residents who meet certain eligibility requirements.

In addition to primary medical care, medication assistance, laboratory testing, imaging studies and patient education, Access Carroll provides specialty care and comprehensive services for patients with chronic conditions.

Mission and Hospital Role

Access Carroll helps the hospital accomplish its mission by improving the health of the community. The community looks to the hospital as a leader, helping to find solutions that improve its health.

The hospital provides a significant amount of intellectual resources, in-kind resources and financial resources. Members of the hospital leadership team are involved in leadership roles at the clinic, and hospital nurses, physicians and clinical staff volunteer their time. Additionally, the hospital's outpatient laboratory and imaging center provide free services to Access Carroll patients.

> Two critical factors have played a role in Access Carroll's success: passionate, committed leadership and a "portfolio approach."

Measuring and Communicating Success

Key measures are monitored and reported back to the community via an annual form and Partnership website. In 2009, Access Carroll provided more than $500,000 of pharmaceutical assistance, 84 specialty providers volunteered $280,000 of free care, and there were more than 7,200 patient visits.

Funding and Sustainability

Both the Partnership and Access Carroll are funded through a combination of sources, including hospital funding, support from the county health department, and tangible donations from the community. The total operating cost for Access Carroll is approximately $1 million annually and the direct cost to the hospital is about $105,000 annually. In addition, the hospital provides testing and professional services (such as laboratory work and x-rays) free of charge to Access Carroll patients. In FY 2010, those critical tests were valued at $369,221.

Advice to Others

To ensure community support and long-term success, it has been important to remain both flexible and open to suggestions and innovative ideas from community partners.

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CHESHIRE MEDICAL CENTER/DARTMOUTH-HITCHCOCK KEENE – Keene, NH

Program: Medical Home

Impetus for the Program

Though they are legally separate organizations, Cheshire Medical Center (CMC) and Dartmouth-Hitchcock Keene (DHK) developed their Medical Home Program to support physicians in the delivery of care to better serve area patients. The program uses a team-based structure that provides needed support for physicians by assuming some of the work and responsibility for care coordination and delivery previously shouldered solely by physicians.

Mission and Hospital Role

They are driven by a shared initiative to become the nation's healthiest community by the year 2020 – a vision that complements the mission of both hospitals. This vision is a collaborative effort of community partners that includes health care organizations, schools, government agencies, businesses and others. Sharing many of the same goals and objectives, the Medical Home Program is an integral part of achieving Vision 2020.

Measuring and Communicating Success

CMC/DHK monitors multiple core measures to determine the effectiveness and efficiency of care delivery. This vigilance has resulted in improved readmission rates for individuals over 65 years of age. The current average for 30-day readmission rate for individuals 65 years and older is 18 percent. Recently, CMC/DHK's readmission rate was 10.4 percent.

The program has received media and business recognition for the leadership and work CMC/DHK provides to best meet the health care needs of the community. Community awareness of the organizations and of the Medical Home Program continues to grow.

Funding and Sustainability

Through their efforts, CMC/DHK has reduced inpatient utilization by 20 percent over the course of the past a few years. Therein lies the problem: in today's fee-for-service reimbursement structure, the hospital's revenue has declined in concert with the reduced utilization, with there being little reimbursement provided for coordination of care. The outstanding question for CMC/DHK is still one of reimbursement.

None of this has dissuaded CMC/DHK from assertively pursuing coordination of care through their Medical Home Program and Vision 2020 as the right way to deliver care.

Advice to Others

Without strong physician/hospital alignment, establishing a medical home and effectively coordinating care is tough to achieve. Integrated teams must be viewed as the answer to managing and improving community health. The strength of the Medical Home Program, the nurses and physicians who work in close collaboration to create and develop it, have made it a success.

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ELMORE MEDICAL CENTER – Mountain Home, ID

Program: Center for Community Health

Impetus for Program

Located in rural Idaho and owned by the citizens of Elmore County, Elmore Medical Center created the Center for Community Health (the Center) to reduce duplication of services and connect local residents with available resources for their health and wellness needs.

Mission and Hospital Role

Elmore Medical Center has incorporated elements of its mission – improving and advancing community benefit programming – as a strategic priority resulting in the creation of the Center. The medical center provides a dedicated staff person in addition to the medical center CEO to work on behalf of the Center and coordinate with community organization representatives, who make up the Center's advisory board. Further, the medical center's board and senior leadership are fully committed to providing the resources necessary to make the Center successful.

> A true partnership must be directed by the community…rather than the hospital. The Center is viewed as a community organization that the hospital facilitates, but is run by community members.

Measuring and Communicating Success

It is difficult to measure the direct impact of the Center when its efforts are not directly clinical; however, future community needs assessments will allow for comparative review of the Center's activities and how they've addressed community challenges. The Center measures attendance and consistently demonstrates strong turnout among area citizens as well as medical center staff. The medical center has become known as the place to call for information about community resources and health and wellness events.

Funding and Sustainability

All initiatives are created based on an identified community need (rather than based on access to a possible grant) and, as such, Elmore Medical Center is the primary funder of the Center's projects, but grants are applied for when possible. In addition to the medical center's resources, the Center's community partners frequently commit resources including volunteer time and tangible donations.

Advice to Others

Enthusiasm must be balanced with careful planning so projects are sustainable and can be easily replicated on a regular basis. It is important to remember that projects can't always be completed within a desired time frame. To make collaborations successful, all partners must be considerate and flexible, including as many people as possible.

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HARRIS COUNTY HOSPITAL DISTRICT – Houston, TX

Program: Community Behavioral Health Program

Impetus for Program

Harris County Hospital District (HCHD) is a public health care system providing more than 1.4 million health care visits annually. Approximately one in four patients seen at HCHD have a psychiatric illness, most commonly depression, anxiety or alcoholism. Wait times for new psychiatric appointments were up to eight months long, forcing many patients to go to the hospitals' busy Psychiatric Emergency Center and creating a frustrating and untenable situation for patients and HCHD alike.

Wanting to improve access to behavioral health care, but without resources to hire needed psychiatrists, HCHD collaborated with area providers to integrate psychiatric services into three HCHD community health centers.

Mission and Hospital Role

The Community Behavioral Health Program (CBHP) advances HCHD's mission daily by improving the community's access to behavioral health services, and delivering those services in patients' own neighborhoods by the primary care physicians and staff with whom patients have the most familiarity and comfort.

HCHD contracts with area psychiatric physicians and provides non-physician staff, including nurses, mid-level providers and administrative staff. HCHD works with a steering committee representing various program stakeholders for ongoing program guidance.

Measuring and Communicating Success

Integrating psychiatric care with primary care within the familiarity of the community's neighborhoods and centers has been key to the program's success. There has been an

18 percent decline in hospital-based psychiatric center admissions as a result of increased access to appropriate community-based behavioral health care. Further, patient "no show" rates for appointments have dropped from 40-50 percent to 25 percent. Patients no longer wait six to eight months for new appointments and instead can be seen within weeks, depending on location. If urgent care is needed, patients can be seen the same day or within the same week. CBHP has been recognized by the American Psychiatric Association and the Texas Hospital Association.

> The program is a demonstration of innovative thinking, collegial relationships, cost-effectiveness, high-quality, safe, patient-centered care that has successfully and significantly improved access to behavioral health care.

Funding and Sustainability

Following a highly successful pilot, CBHP was implemented with a one-year start-up grant from the Hogg Foundation for Mental Illness. Abbott Laboratories provided an educational grant to support development of training DVDs and audiotapes. Since 2006, HCHD has fully funded the program.

Advice to Others

Develop training programs, DVDs and audiotapes focused on educating primary care physicians on the medication groups. This can help overcome concerns on lack of familiarity and knowledge of psychiatric medications. Additionally, with psychiatrists and behavioral health specialists at the centers, specialty support is available whenever primary care physicians need it.

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JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY – Chicago, IL

and

MOUNT SINAI HOSPITAL – Chicago, IL

Program: Chicago Hospital to Housing Program

Impetus for Program

The Chicago Hospital to Housing Program (CHHP) was formed in 2002 to address a common and unfortunate situation: homeless people are discharged from hospitals and end up back on the streets without the regular medical care they need. While respite care provides more than a homeless shelter can offer – a warm place for people to sleep, as well as housing during the day, three full meals and supervised care, such as reminding patients to take their medication – there was a lack of sufficient settings.

Mission and Hospital Role

CHHP aligns closely with the mission of John H. Stroger Jr. Hospital of Cook County (Stroger Hospital) and Mount Sinai Hospital, improving the health of the community while treating patients with greater respect and dignity.

A consortium of hospital and community agencies called the Continuum for the Homeless transitioned to become CHHP and among this group, Stroger Hospital and Mount Sinai Hospital are the primary hospital partners. Originally, the hospitals identified individuals who could participate but that role has grown to include hospital-based, full-time, grant-funded case managers that determine which patients are a good fit to be involved in the program. Case managers refer patients to the appropriate next level of care – generally social workers employed by the various community agencies – and provide intensive case management to ensure that patients' follow-up needs are met. Physicians also can refer patients to a CHHP case manager.

> Success cannot be achieved by one organization – it requires a collaborative approach with all community organizations working together. Hospitals have a unique opportunity to facilitate a partnership and bring people together around this shared goal.

Measuring and Communicating Success

An 18-month study demonstrated that homeless patients who received respite care had 24 percent fewer ED visits and 29 percent fewer hospitalizations. In addition, emergency department employees report higher workplace satisfaction because they feel they are more effectively able to care for patients and meet their needs. Public awareness of the program has bolstered public support for the hospitals.

Funding and Sustainability

CHHP is funded by a combination of private grant funding, federal funding, and support from other local non-profit organizations. The hospitals' case managers are both supported by grant funding, with the hospitals providing office space and other needed support such as a computer and telephone service.

Advice to Others

Building trust with homeless patients is critical. Many program participants have been on the street for some time and try to disconnect themselves from formal establishments and organizations. Sometimes they end up in the ED involuntarily because they were brought in by ambulance. Case managers must first build trust with homeless patients before the patients are willing to participate.

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LIVINGSTON HEALTHCARE – Livingston, MT

Program: Park County Pediatric Community Care Team

Impetus for Program

One of the greatest challenges for families needing services for their children is trying to keep track of the various organizations, agencies and services available. To help children and families avoid disjointed care and confusion, Livingston HealthCare worked with others to develop the Park County Pediatric Community Care Team, a collaborative of 14 organizations that provide medical, social and educational services.

The Care Team improves access to pediatric services, provides resources and information to children and their families, and expands or develops programs to meet the needs of Park County's youth. The Care Team also focuses on streamlining services to reduce or eliminate duplication.

Mission and Hospital Role

A cornerstone to Livingston's mission is to better serve its community, a goal that the Park County Pediatric Community Care Team helps to achieve. Livingston HealthCare spearheaded the effort to form the Care Team, but it is now an equal partner in the initiative.

Measuring and Communicating Success

The Park County Pediatric Community Care Team has had a positive impact on the quality of care patients receive as well as the hospital's reputation in the community. For patients, problems are addressed more quickly.

The Care Team has conducted community-wide surveys assessing the needs of children ages 5-12 and holds a popular annual event, Ready, Set, Grow!, which conducts health screenings linking children in need with appropriate resources.

Funding and Sustainability

The Care Team is a joint effort among all 14 of the core partners and currently relies primarily on partner resources and donations. Many of the pediatric patients the hospital cares for are Medicaid patients with reimbursement that does not cover all costs; however, the goal of the partnership is not to bring in additional revenue, but to better meet the needs of the community.

> Helping parents meet their children's developmental needs early and in a coordinated manner ultimately improves their quality of life and reduces health care costs.

Advice to Others

In addition to the involvement of the core members, building relationships with other community stakeholders is key to the Care Team's success. Community organizations are willing and interested in partnering to help streamline care for patients and eliminate the frustrations and confusion that families often face. It simply required the hospital's initiative to bring all the key players together.

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POUDRE VALLEY HOSPITAL and POUDRE VALLEY HEALTH SYSTEM – Fort Collins, CO

Program: Community Case Management Program

Impetus for Program

The Poudre Valley Health System (PVHS) Community Case Management Program was created to better help patients manage their chronic conditions and prevent unnecessary readmissions to the hospital.

Serving primarily seniors, the program helps educate clients and create a continuum of care by developing a network of community resources and services that helps to meet each client's needs and potentially prevent an unnecessary return to the hospital. The program's six case managers work with approximately 400 clients per year.

Mission and Hospital Role

The Community Case Management Program reflects elements of PVHS's mission – innovation, comprehensive care, high quality, patient satisfaction and value.

Prior to the program's establishment, many resources were available, but few knew of their existence. There was no coordination of the community resources available. Identified by the board as a strategic plan initiative and sponsored by the hospital, the Community Case Management Program serves as a referral center for community services. The program's advanced practice nurses and medical social worker have developed a broad network of resources and partnerships throughout the community that works in collaboration to meet the needs of the community's at-risk senior population.

Measuring and Communicating Success

The program has received multiple awards, which help increase awareness. Outcomes are measured in multiple ways. Patient usage for both ED visits and inpatient stays is measured six months prior to the program's intervention, and then again six months following participation in the program. Year after year, the program has demonstrated a 50 percent reduction in emergency and inpatient visits.

Additionally, the program measures client satisfaction, which consistently ranks case management as excellent (72 percent) or good (28 percent) for its effectiveness in "making a difference in your situation."

Funding and Sustainability

The Poudre Valley Hospital is the sole sponsor of the Community Case Management Program, absorbing all costs. The hospital estimates that the program has helped them avoid approximately $2 million a year in unnecessary or preventable care (just on new clients), a savings that far exceeds their investment in the program.

Advice to Others

Re-frame the picture of program costs. The program's impact and benefits extend far beyond simple reimbursement. Count benefits such as reduced ED visits and inpatient stays, avoided costs of facility expansion and equipment purchases driven by reduced emergency visits and prevention of admissions, not to mention the benefits derived from providing services that help improve the health and well-being of clients and the community the hospital serves.

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PROVIDENCE CENTRALIA HOSPITAL – Centralia, WA

Program: CHOICE Regional Health Network

Impetus for Program

Created in 1995, CHOICE, which stands for Consortium of Health systems Organized In Collaborative Effort, was the result of rural hospitals working together to understand state-passed health reform. The state's health care reform legislation was repealed two years later, but the CEOs continued collaborating with a goal of providing better health care at lower cost.

Today, its membership includes rural and urban hospitals, practitioners, public health agencies, clinics, community health centers, behavioral health providers and other partners dedicated to improving the health of Central and Southwestern Washington. Efforts focus on four core areas: access to care, quality improvement, community development and advocacy.

Mission and Hospital Role

CHOICE is co-sponsored by hospital leaders in the five counties served, as such CHOICE closely aligns with multiple missions, helping hospitals reach out to the poor and vulnerable in new ways. The leadership team at Providence lends their leadership skills to the collaboration as well.

Measuring and Communicating Success

In 15 years of service, CHOICE has worked with approximately 85 percent of the uninsured population in the five-county region served. At any time, about 300 clients are being served by the Network's intensive client services. Annually, CHOICE helps more than 3,000 clients with health coverage, access and other services.

In addition to providing quarterly progress reports to the CHOICE Board of Directors, CHOICE collects and reports information about its impact on the community via website and annual reports.

Funding and Sustainability

The Network has reduced ED use among the identified patients by half, for an annual savings of roughly $9,000 per patient. Joint planning like this is essential in rural areas like Central Western Washington, where it's necessary to coordinate and pool resources.

CHOICE's annual operating budget is approximately $1.5 million. Member dues support between 10 percent – 25 percent of the total budget, and grant funding supports the rest of the Network's operations. Hospitals in the five-county area all pay dues based on their net operating income, which makes the support equally weighted among all the hospital contributors. St. Peter Hospital also pays an additional $50,000 to support the Project Access program.

> While hospitals may be competitive with one another in the marketplace, they can simultaneously be collaborative in delivering non-competitive services, such as helping patients get care at the right location, preventing duplication of unnecessary care and increasing access to care.

Advice to Others

In most communities, hospitals are the entity with the needed influence to rally key community leaders around the development of a collaborative network similar to CHOICE. Hospitals should be co-owners of the effort and should contribute CEO-level leadership on the network board.

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PROVIDENCE HEALTH & SERVICES – Hawthorne, CA

Program: Vasek Polak Health Clinic

Impetus for Program

Providence Health & Services created the Vasek Polak Health Clinic to meet the primary care needs of uninsured and underinsured adults living in and around Hawthorne, a Los Angeles County community. The Health Clinic alleviates some of the stress on the ever-more-crowded EDs in the region, creating a medical home that provides more coordinated and consistent care for uninsured and underinsured patients, particularly for people with chronic conditions like diabetes and high blood pressure.

Mission and Hospital Role

The Health Clinic is a direct extension of the organization's mission, providing much-needed care to the poor and vulnerable. It is the result of several organizations working in collaboration to meet a critical community need. The clinic is operated by the medical foundation Providence Medical Institute, is a business entity of Providence Health & Services in California, and is a sister organization of Providence Little Company of Mary Medical Center in Torrance, CA. The clinic's non-physician staff are employed by the Providence Medical Institute, while physicians are employees of their own fully aligned physician group called Providence Medical Group.

Measuring and Communicating Success

When it first opened in 2007, the clinic was caring for just over 100 patients per month. In July 2010 the number of visits was up to 600 per month. In addition, the clinic provides a more appropriate care setting for patients who previously may have relied on the emergency department as their only source of care.

Patients are happy with the care that they receive and the clinic's education programs are having an impact. For example, dozens of patients have graduated from the clinic's diabetes education class, which provides the knowledge and support they need to start eating the right foods and control their blood sugar. This kind of education program positively influences the number of people who would otherwise end up in the local ED for problems associated with chronic conditions.

Funding and Sustainability

When the clinic was initially created, the Providence Little Company of Mary Foundation sought grant funding for start-up costs from the Vasek and Anna Maria Polak Charitable Foundation. Grant funding still provides some operational support but additional operations are

funded by Providence Health & Services in California. Although the clinic will never be profitable, the program will remain sustainable in the long term through its $50 fee for primary care visits as well as financial assistance from Providence Health & Services.

Advice to Others

As with any program targeting unmet community needs, it is essential to evaluate the local community to gain a deeper understanding of the greatest needs. Once those needs are identified, the hospital should work with local community organizations to develop a program that best meets local needs. The hospital also should leverage community partnerships and relations to ensure that those in need of the program are made aware of the services available.

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WEST VIRGINIA UNIVERSITY HOSPITALS CITY HOSPITAL – Martinsburg, WV

Program: VITALS – Vital Aspects of Life Services

Impetus for Program

To reduce hospital readmissions for Berkeley County patients with diagnoses of congestive heart failure, chronic obstructive pulmonary disease or diabetes mellitus, the West Virginia Bureau of Senior Services used federal grant funding to develop a pilot program titled the Vital Aspects of Life Services (VITALS). City Hospital is one of two pilot hospitals for the program, every City Hospital patient with one of these three diagnoses is asked to participate in the program, which is offered at no charge to the patient.

Mission and Hospital Role

Participating in a demonstration program such as VITALS incorporates the hospital's mission by developing, researching and evaluating a model of care delivery that is expected to deliver high-quality, cost-effective health care services for the Berkeley County community.

Through VITALS, the hospital identifies appropriate patients ready for discharge and links them with social workers who can structure a patient-centered support system designed to help the patient maintain a level of health and wellness that may prevent the need for hospital readmission.

Measuring and Communicating Success

The support provided by the VITALS program is designed to engage patients in the discharge process and provide information and tools needed for patients to self-manage their chronic conditions. The program also is recognized for the relief and assistance it offers to the patient's family caregivers. By effectively transitioning care from the hospital to home and managing follow-up needs, readmissions to the hospital are expected to be prevented and patients may remain in their homes, a more cost-effective, patient-centric way to spend precious health care dollars.

Funding and Sustainability

The VITALS program is supported by a three-year federal grant. As an "intervention" or pilot hospital in the program, City Hospital is paid $20,000 a year for its participation. The Bureau is hopeful that if the program is successful, City Hospital and other hospitals will help provide funding for future operations. Like many, City Hospital recognizes not only the intrinsic value of preventing patient readmission, but also the fact that hospital responsibility for preventing readmissions is a critical focus for the U.S. Department of Health and Human Services and is addressed in the Patient Protection and Affordable Care Act.

The success of the VITALS program and the potential lessons to be learned from it are expected to lead to potential cost savings not only for City Hospital, but also for Medicare and Medicaid programs.

> The program is built on the belief that identifying patients for discharge, engaging them in the discharge process and providing more individualized, intensive support following discharge is preventive care in the truest sense.

Advice to Others

To streamline administration and reduce paperwork and costs, particularly for a larger scale program, ensure participating organizations have the information technology necessary to transmit information electronically.

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PARTNERING
ON WELLNESS

PARTNERING ON WELLNESS
EXECUTIVE SUMMARY

Impetus for Programs

Hospitals and health systems across the country are committed to missions that emphasize providing and caring for the community, and they view community wellness as a critical factor in improving community health. The primary focus of their wellness programs is no surprise—lifestyle factors like nutrition and fitness that lead to obesity and other chronic diseases that are preventable but are becoming more prevalent and more costly. Unhealthy lifestyles and the growth in chronic disease are increasingly affecting individual quality of life and overall community health. According to the Centers for Disease Control and Prevention, one in every three adults is obese, and almost one in every five youths between the ages of 6 and 19 are obese. In addition, chronic diseases such as heart disease, stroke, cancer, diabetes and arthritis are recognized as the most common, costly and preventable of all health care problems in the United States.

- **Targeting the greatest community needs.** All of the wellness programs highlighted in this Insight Series were developed in response to public health needs. Some of the needs were identified as a result of a community needs assessment conducted by the hospital or health system, while others were well-known community health challenges that hospital employees and leaders had identified through their regular interactions with patients and the general community.
- **Focusing primarily on improving the coordination of existing resources.** Many programs harness efforts already underway to address health challenges that have become increasingly prevalent throughout the country: weight and obesity-related chronic illnesses such as heart disease and stroke; childhood obesity and the corresponding rise in type 2 diabetes; and the need for early childhood services. They also focus on meeting the needs of an aging population, whose issues range from depression and prescription drug addictions to falls and chronic disease. Most of the wellness programs target underserved or at-risk patients.

> Our coalition has been so successful because of the commitment and dedication of each of our partners. Each organization has committed resources, whether financial or in-kind, to make sure our programs have the necessary tools to teach children about the importance of making healthier food choices and staying active.
>
> Julie Edwards, Community Benefit Manager,
> Provena Saint Joseph Medical Center

Mission and Hospital Role

- **Hospitals and health systems extend the mission into the community.** Many of the wellness programs' successes are the result of establishing multiple service locations in the neighborhoods where the need is greatest and programs can deliver the most benefit. Partnering with local organizations outside of the hospital takes the programs into the neighborhoods, schools and community locations that can most effectively reach those in need. Reducing transportation barriers and increasing the familiarity of the location encourage higher levels of program participation.
- **Hospitals and health systems are often the primary facilitators and provide resources for core activities.** In most cases, hospitals are the primary facilitators of the program partnerships, inviting key stakeholders to the table and helping to coordinate the best use of pooled resources to minimize duplication and capitalize on the expertise and experience of various organizations. Many partners provide needed and valuable in-kind resources that can stretch limited budgets and maximize the impact on the community. Hospitals typically "anchor" community health and wellness programs, providing program leadership and oversight. Many are often responsible for the day-to-day operations, and may provide office space, training or staff support.
- **Every partner plays an important role.** Every community organization and partner plays a vital and critical role, regardless of how big or small their size. Although different organizations may have varying degrees of involvement, successful wellness partnerships and initiatives encourage each partner's engagement, accountability and participation in decision-making.
- **Hospital and health system leaders are involved.** Every community organization and partner plays a vital and critical role; however, hospital and health system leaders are actively involved, supporting the programs through dedicated staff involvement, participation in advisory boards and attending events. Hospital and health system boards also are committed to supporting these mission-driven programs. Some boards have a designated committee that oversees community health and wellness programs, while other organizations regularly provide updates to the full board. When the community wellness programs include a separate advisory committee or board, board members often serve in leadership roles on those committees and boards in addition to their hospital commitments. Many trustees also attend local community wellness events to personally support the organizations' efforts.

Measuring and Communicating Success

Accountability is increasingly important in today's health care environment, a factor that is not overlooked in community health and wellness programs. Many of the wellness programs included in this series have tracked specific measures and indicators to demonstrate their program's impact.

- **Health indicators and provider performance.** Most organizations track program success by measuring health indicators of participants or the community at-large. These measures include blood pressure, cholesterol, body mass index, stress levels and other indicators of physical health. When delivery of personal health care is included in a program, hospitals often measure quality and performance indicators much like they would when treating hospital patients.
- **Enrollment and participation.** Programs that are focused on early childhood intervention and access to care often track Medicaid enrollment, as well as intervention program enrollment and education attendance. For programs that are dependent on enrollment, such as childhood intervention, hospitals also track referrals from local providers. Engaging local providers in program creation and ongoing development is essential to ensuring physician referral and individuals' participation in many of the programs.
- **Improved public awareness about the benefit provided by the hospital.** Hospitals undertaking community health and wellness initiatives consistently report that not only are the programs helping improve the community's health and elevating individuals' quality of life, they are resulting in improved public awareness of the benefit the hospital provides to the community. Working with local community partners to address health needs is a sound public relations strategy, and a tremendous way to garner public support for the hospital as a vital community resource and trusted community partner.

Funding and Sustainability

Although many community health and wellness initiatives are partnerships with other organizations, the responsibility for program funding and sustainability generally rests with the hospital or health system. How each organization funds its efforts is a function of the scope of the initiative, the resources available, the needs unique to the community and the scope of internal resources available.

- **Funding approaches vary but generally rely on hospital resources in some form.** Some organizations provide one-time donations for program start-up costs and new initiatives as they arise, while other hospitals include the programs as a part of their annual budget. Many programs are either supplemented with grant funding, corporate and/or community donations, or are fully funded by external grants and donations. Often hospitals apply for grants that help launch their program and support it for the first few years. Once these grant-funded programs are successfully in place, they typically transition to being hospital-operated and sustained.
- **Hospitals offer internal resources to stretch funding sources.** In addition to providing financial support and/or actively seeking external support for their community health and wellness programs, many hospitals apply their internal resources to make the programs successful, including staff, training and use of hospital facilities and technology. The generous support of hospitals and their community partners ensures that most community programs are offered free, or at a nominal cost for participants.

> The ENERGIZE! program is successful because we are bringing families together and teaching them to work as a team making healthy choices about physical activity and nutrition.
>
> Julie Paul, ENERGIZE Program Coordinator,
> WakeMed Children's Diabetes and Endocrinology

Advice to Others

Hospitals and health systems operating community wellness initiatives offer the following tips for success: stay focused on the hospital mission, partner with other organizations and conduct a community needs assessment.

- **Stay focused on the hospital/health system mission.** Partnering for wellness initiatives is an extension of hospital/health systems' mission statements and is the primary motivation for investing time, resources and money in a wellness effort. Hospitals should continually evaluate their progress in fulfilling the mission, not losing sight of the connection between their mission and the community's health.
- **Partner with other organizations that share similar goals.** Successful and effective community health and wellness initiatives cannot be achieved in a silo. Seeking partnerships with organizations that have similar goals maximizes resources, minimizes duplication and helps to ensure that programs reach those who need it the most, all of which contributes to a greater benefit to the community and hospitals' fulfillment of their missions.
- **Partner with organizations that can increase access to populations in need.** Partnering with organizations that have a strong reach or connection within a specific community or population will allow hospitals to more effectively reach those in need.
- **Conduct a community needs assessment.** Before undertaking a comprehensive and resource-intensive community health initiative, make sure that the program meets the community's needs. Conducting a community needs assessment helps identify and prioritize the community's needs and challenges, preventing a disconnect between real community needs and what the organization thinks the community needs.

CABELL HUNTINGTON HOSPITAL – Huntington, WV

Program: Healthy Lifestyles Promotion

Impetus for Program

Recognizing that the community struggled with weight and obesity-related chronic illnesses, Cabell Huntington Hospital (CHH) turned negative media attention into a catalyst for engaging its community and orchestrated a multifaceted initiative to change attitudes and habits about healthy eating and living. CHH is partnering with area organizations including public schools, the YMCA, the local mall and international chef Jamie Oliver.

Activities included collaboration with a local NBC affiliate to create "Healthy Tri-State's Biggest Loser," which featured local contestants learning how to live a healthier lifestyle, and regular health tips broadcast throughout each day.

Working with Jamie Oliver and his televised Food Revolution, CHH sponsored a school lunch program that improved the menus at all 28 public schools in Cabell County in addition to funding a community kitchen that teaches residents healthier ways to choose and prepare food.

The hospital also brought the community an indoor space for children to play, creating the Healthy Kids Play Place in the local mall.

Mission and Hospital Role

Maintaining an emphasis on health care education is a primary mission of CHH. The hospital continues to work closely with multiple organizations to transform long-standing health trends, often initiating efforts or providing sponsorship to existing initiatives.

Measuring Success and Communicating Outcomes

There has been a strong increase in awareness of the problems associated with obesity and how to eat and live healthier. Recent studies suggest CHH's efforts are working and the long-standing obesity trend is reversing. With such public elements to its initiative, CHH regularly works with local and national media to promote lifestyle changes and set the record straight on Huntington's health record.

Funding and Sustainability

CHH has donated $100,000 to the Jamie Oliver Project and $50,000 to Huntington's Kitchen.

Advice to Others

Though hospitals rely on the provision of acute care services to the sick and injured for their financial well-being, they should not ignore health and wellness promotion as part of their overall mission to improve the health of their communities.

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CHILTON MEMORIAL HOSPITAL – Pompton Plains, NJ

Program: New Vitality

Impetus for Program

In response to growing needs of the older adult population in the hospital's service area – from battling depression and prescription drug addictions to decreasing falls and the incidence of chronic disease – Chilton Memorial Hospital developed a free health and wellness program for adults age 50 and over.

Working with numerous collaborative partners, almost 40,000 individuals participate in the program, receiving a quarterly newsletter that lists available classes, groups, lectures and workshops. Most classes and lectures are at maximum capacity.

Mission and Hospital Role

New Vitality aligns with Chilton's mission to provide health and wellness to its community. The hospital is responsible for the day-to-day operations including coordination with current participants and community partners including the local police department and YMCA as well as outreach to potential community partners.

Hospital leadership is actively involved. The CEO and president of the hospital's foundation board sit on the New Vitality advisory board and trustees attend many of the program's events and classes.

> Offering this type of programming is a win-win situation for hospitals that want to associate with providing preventative health and wellness programs in their community.

Measuring and Communicating Success

After every program, New Vitality surveys participants to measure results, from post-exercise class blood pressure to post-lecture surveys on the likelihood of participants altering their habits.

The program has resulted in serendipitous public recognition by many members of the community and word of mouth has been the strongest publicity tool.

Funding and Sustainability

Chilton fully funds the New Vitality program with some small grants supplementing select services. Excluding three staff salaries, which the hospital covers, the annual operating budget is approximately $175,000, including a vehicle for transporting participants.

Advice to Others

This is a tremendous way to build community involvement, and in turn, garner support for the hospital's foundation.

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CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER – Cincinnati, OH

Program: Every Child Succeeds

Impetus for Program

In 1999, Cincinnati Children's Hospital, the United Way of Greater Cincinnati and the Cincinnati-Hamilton County Community Action Agency founded Every Child Succeeds in response to community concern for the health and development of young children ages 0-3. The resulting prevention, early intervention program for at-risk, first-time mothers has resulted in lower infant mortality rates.

The program is guided by scientific research and focuses on documented outcomes confirming that a stimulating and nurturing environment is essential for optimal brain development, which in turn leads to readiness for school and improved physical and behavioral health. This is achieved by working with 16 provider agencies whose nurses, social workers and child development specialists provide home visits for mothers from pregnancy through a child's third birthday.

Mission and Hospital Role

Every Child Succeeds' mission is to offer area first-time mothers and their families support to ensure an optimal start for their children. The program aligns with Cincinnati Children's commitment to improving child health and its quality improvement strategy. Hospital leadership actively participates in the program's development and management.

Measuring and Communicating Success

With a robust data collection and evaluation system, Every Child Succeeds can demonstrate the positive outcomes of its evidence-based programming and services.

The very collaborative nature of the program provides an excellent forum for communication. Since the demand is greater than what the program can accommodate, Every Child Succeeds is not advertised, although all founding partners proudly detail their involvement and the successful results.

Funding and Sustainability

Every Child Succeeds is funded through a public/private partnership that includes Cincinnati Children's, United Way, Medicaid, state and county dollars, and personal and corporate donations.

Advice to Others

Oftentimes, a larger organization like Children's Hospital can be seen as a threat to smaller community organizations, so it is essential that a true partnership is formed and maintained. In this way, everyone is seen as (and works as) a resource and a productive member of a team.

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HOLY CROSS HOSPITAL – Taos, NM

Program: Taos First Steps

Impetus for Program

To maximize the impact of local, early-childhood services, area providers – from Holy Cross Hospital and the local midwifery center to an early childhood resource center and local branch of the University of New Mexico – work together to support first-time parents in Taos and Western Colfax counties.

In 2006, Holy Cross formalized the effort earning state grant funding for a home visiting service model of care. Reflective of the "first steps"

that both child and parents make as the family grows and changes, the program connects each family with a home visitor who works with the family from pregnancy to the child's third birthday.

The six-month pilot program was a success and First Steps has been a part of more than 200 families' lives since 2007.

Mission and Hospital Role

The program exemplifies the importance Holy Cross places on giving the community not only a place to get cured, but also a place to get information. The hospital provides ongoing support, from both the CEO and board level as well as financial management, marketing and promotional services and development and training for staff.

Measuring and Communicating Success

Ninety-nine percent of children participating in First Steps have regular access to medical care and 95 percent receive well-child visits. Additionally, babies born to moms that are a part of First Steps have better birth weight, averaging one pound bigger than infants of mothers who did not participate in the program.

> Apply a multi-disciplined approach to stretch modest budgets and provide comprehensive assistance.

Funding and Sustainability

Funding is provided by New Mexico's Children, Youth and Family Department, and First Steps costs about $3,000 per family, per year.

There are currently plans to replicate the program throughout the state.

Advice to Others

Instead of focusing immediately on impact, track how many referrals are coming from local providers and spend early years working to secure community support so that the program can help those who need it most.

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IOWA HEALTH – Des Moines, IA

Program: Center for Healthy Communities

Impetus for Program

In 1993, three Des Moines-area hospitals merged creating the state's largest integrated health system, and also its first. To better address the needs and concerns of the community and also coordinate existing organizational outreach programs, the hospital system created the Center for Healthy Communities as its own department, with designated financial resources and full-time staff.

The Center links resources with identified community needs, leverages partnerships, and serves as an incubator for new ideas and programming projects. Key partners include the Polk and Dallas County Health Departments and the United Way. Since 1995, the Center has established collaborative, community-based clinical initiatives such as the Latina Family Health Project and the first school-based health center in Des Moines.

Mission

The Center takes the health system's mission – to improve the health of its community through teaching, healing and caring – beyond the hospital walls, providing care through clinics, youth mentoring, health education and leading community health needs assessments.

> To be effective, organizations must be responsible partners. It is important to practice discernment and participate when you can be an engaged and contributing partner.

Hospital Role

As its own department within the health system, the Center takes the lead on collaborative projects, providing leadership and financial resources for programming initiatives.

Measuring and Communicating Success

The Center has become a trusted and respected community partner and, as a result, is often approached to provide leadership, management or foster development of community projects.

Funding and Sustainability

In addition to designated annual department funding, the Center also has secured grant funding, such as a federal HCAPS grant, to supplement efforts.

Advice to Others

Hospitals have wonderful and numerous resources, but to leverage those resources appropriately, one must take the time to listen and learn what is going on and how your organization can best fill the community's needs.

It is important to practice discernment and participate when you can be a responsible and contributing partner.

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LAWRENCE AND MEMORIAL HOSPITAL – New London, CT
and
WILLIAM W. BACKUS HOSPITAL – Norwich, CT

Program: New London County Health Collaborative

Impetus for Program

Led by a mission of improving the community's health status through collaboration, area organizations and businesses have worked together since 2007 to positively address high rates of obesity, smoking and chronic disease as well as a lack of physical activity among adults in New London County.

The scope of activity has grown over the years and the Collaborative now educates the state's legislative delegation and local policymakers on important health issues, advocating for changes that benefit the health of the county.

> The goal that drives the network is getting this population the right care at the right time, and preventing their condition from becoming an emergency situation.

Mission and Hospital Role

A commitment to improving the overall health of the community drives the hospitals' activities and similarly, the mission of the Collaborative is to improve the health status of the community by working together. Leaders from both organizations are actively involved and executive-level leaders from several members oversee all Collaborative activities. Lawrence and Memorial Hospital contributes 10 staff hours a week and Backus Hospital contributes in-kind staff time. Both hospitals provide periodic meeting space.

Measuring and Communicating Success

Initial efforts focused on connecting underinsured or uninsured individuals to a system of specialty care providers – specifically cardiac care – for needed medical care.

Building on the program's success, additional specialty care areas are being considered.

Funding and Sustainability

The Collaborative is funded almost entirely through a dues-paying structure determined by the size of an organization. Special grant funding established the Collaborative's specialty care network and allows for its continued development.

Advice to Others

As with any long-term group endeavor, it is critical to maintain a sense of momentum. The excitement of responding to a needs assessment is followed by the need to revisit the strategic planning stage and determine next steps.

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PROVENA SAINT JOSEPH MEDICAL CENTER – Joliet, IL

Program: Healthy Kids Club Initiative

Impetus for Program

To fight childhood obesity, Provena Saint Joseph partners with the local school district – which serves more than 11,000 students – local parks, area universities, the YMCA and others to provide the Healthy Kids Club Initiative.

The initiative, under the Joliet Partners for Healthy Families, targets families in areas where more than 50 percent of children live in poverty. The areas are generally both ethnically and racially diverse. The focus of the initiative is to teach proper nutrition and exercise through three unique after-school programs: Camp Fitness, Kids 'n Nature and Smith Opportunities for Activities and Recreation (SOAR).

Mission and Hospital Role

The mission of the Joliet Partners for Healthy Families is to enhance the quality of life for all ages, abilities and ethnic backgrounds by encouraging good nutrition and physical activity. At the same time, there is a strong focus on underprivileged children. This fits perfectly within Provena Saint Joseph's mission: to "build communities of healing and hope," especially targeting underserved communities.

Provena Saint Joseph Medical Center actively engages other partners and community members in developing Healthy Kids Club programming. Funding comes primarily from the hospital and the school district with supplemental support from grants. Other partners provide needed and valuable in-kind resources, such as staffing and healthy snacks.

> It is critical to ensure that every partner in the collaborative is engaged, accountable and able to make decisions… it is important to make sure everyone has a voice and gets credit for the work.

Measuring and Communicating Success

All Healthy Kids Club programs utilize quality measures and all demonstrate positive results. There also have been positive unintended outcomes, such as positive changes in social interaction and leadership skills for participants. Additionally, Healthy Kids Club has raised community awareness of the hospital's commitment to the community.

Funding and Sustainability

Healthy Kids Club is funded through Provena Saint Joseph's Community Benefit budget and the Joliet District 86 budget. Grants and in-kind donations from partners supplement activities.

Advice to Others

At the beginning of an initiative, make sure partnership commitments go beyond the first year. These kinds of programs take time to build and to yield results, so it is important for everyone involved to be in it for the long run!

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ST. ELIZABETH HEALTHCARE– Edgewood, KY

Program: Northern Kentucky Women's CARE Collaborative

Impetus for Program

In Kentucky, 38 percent of all deaths are the result of heart disease or stroke, a striking statistic which inspired St. Elizabeth Healthcare to partner with 49 organizations – including schools, physicians, churches, businesses, county and state health departments – to create the Northern Kentucky Women's Cardiovascular Assessment, Risk Reduction and Education (CARE) Collaborative.

Timed to capitalize on a U.S. Department of Health and Human Services (HHS) grant for hospitals collaborating with community partners, the CARE Collaborative raises awareness about hypertension and encourages women, as well as men and children, to adopt healthy lifestyle habits through its Know Your Numbers! campaign. Activities include blood pressure screenings, cardiovascular health education, and intensive lifestyle interventions when needed.

Mission and Hospital Role

The CARE Collaborative is driven by its mission to educate the community and counter the high occurrences of cardiovascular disease in the state.

St. Elizabeth's leads many Collaborative efforts including administering blood pressure screenings, coordinating data from other partners and overseeing a long-term research study which is a key component of the program.

Measuring and Communicating Success

Through the ongoing, long-term study on heart health in women, results are well measured. A total of 587 participants have had their blood pressure, cholesterol and lifestyle habits recorded over time, using a tracking card developed for this study. Preliminary results show improved blood pressure, cholesterol and weight levels. In addition to study participants, more than 15,000 individuals have lowered their blood pressure.

Funding and Sustainability

An annual, $500,000 HHS grant, good for three years, enabled the Collaborative to develop and distribute materials, set up educational kiosks, as well as fund a long-term study. Plans are underway to sustain activities when the grant expires.

Advice to Others

Identify potential community partners who may have similar goals to what your program seeks to achieve and invite them to participate.

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WAKEMED HEALTH & HOSPITALS – Raleigh, NC

Program: ENERGIZE!

Impetus for Program

The Children's Diabetes Program at WakeMed Health & Hospitals regularly received numerous calls from pediatricians looking for help with an increasing number of children diagnosed – or headed toward diagnosis – with type 2 diabetes.

In response, the hospital developed ENERGIZE! to teach young people and their families how to build lifelong, healthy attitudes about food and fitness. The screening, education and exercise program identifies children ages 6-18 with type 2 diabetes, pre-diabetes or metabolic syndrome.

> At least 60 percent of ENERGIZE! participants are Medicaid recipients whose families often lack the knowledge to keep diabetes at bay or the resources to enjoy fitness and nutrition classes that are offered free through the program.

Mission and Hospital Role

ENERGIZE! complements the mission of WakeMed, to provide outstanding and compassionate care to all, by effectively reaching underserved individuals.

WakeMed developed the 12-week, three-nights-a-week community-based program providing nutrition, education and physical activity curricula that are implemented at various locations. Sessions are taught collaboratively by WakeMed clinicians and ENERGIZE! fitness partners. WakeMed provides program oversight and nutrition and behavioral change curriculum and training. Fitness partners such as the YMCA, Boys and Girls Clubs and Parks and Recreation Department provide the fitness activities and direct the fitness portion of the intervention using resources unique to their facilities and expertise.

Measuring and Communicating Success

ENERGIZE! collects data on participants ranging from BMI to lab values to fitness tests and tracks attendance and completion rates. Results demonstrate that participants have lowered and maintained steady BMI levels. ENERGIZE! is referral-based, since physicians are the gateway for many families, most communications focus on medical providers and facilities.

Funding and Sustainability

ENERGIZE! was originally funded through a grant awarded to WakeMed but is now transitioning from grant support to a WakeMed operated and sustained program. The lack of insurance reimbursement is a challenge. Interventions like this work, but few insurers see the value in prevention.

Advice to Others

Having various community partners around the table has resulted in helpful learning and increased ability to build a program that best serves a variety of children and their families. It allowed for creation of a robust program without reinventing the wheel.

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SUMMARY/CONCLUSIONS

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

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

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

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

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Photos

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

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