

Hospital-Community Partnerships  
to Build a Culture of Health:

**A Compendium of**  
**Case**  
**Studies**

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# Introduction

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In 2016, the Health Research & Educational Trust, an affiliate of the American Hospital Association, launched *Learning in Collaborative Communities*, a cohort of 10 communities from across the United States that have successful hospital-community partnerships. This work was part of the Robert Wood Johnson Foundation's vision to build a Culture of Health. HRET staff visited the communities and met with representatives from the hospital and community to learn how these individuals and their organizations worked together to build effective partnerships. In addition, three representatives from each of the communities were invited to two in-person meetings dedicated to strengthening competencies related to building effective hospital-community partnerships.

Insights gained from these site visits and meetings helped HRET create "[A Playbook for Fostering Hospital-Community Partnerships to Build a Culture of Health](#)." The playbook includes strategies, worksheets and tools to guide a structured and collaborative process for improving the health of individuals and communities.



**These case studies highlight communities that are developing, implementing and sustaining effective strategies and successful programs to achieve a Culture of Health.**



## Key takeaways from the playbook include:

- Partnerships share valuable assets such as resources, tools and expertise.
- Hospital-community partnerships are necessary to address community health issues nonclinically.
- The process of identifying partners and assets and developing an action plan can be simplified by incorporating structured activities and exercises.
- Aligned goals, transparent communication and strong leadership can drive a partnership to measurable success.
- Leveraging strengths and identifying weaknesses in a partnership help overcome challenges.
- Evaluating, reflecting on and celebrating progress strengthen a partnership and accelerate momentum.
- Sustainable partnerships are established by including more innovative strategies and practical tools in existing practices.

This compendium features descriptions of the communities—which vary in location, service type, type of partners and degree of partnership—and their initiatives to build a Culture of Health. The appendix includes photos from the two meetings convened by HRET with representatives from the communities as well as the Robert Wood Johnson Foundation.

Atlantic Health System	<b>Morristown</b>	New Jersey
LifeBridge Health	<b>Baltimore</b>	Maryland
Providence Health	<b>Portland</b>	Oregon
Seton Healthcare Family	<b>Austin</b>	Texas
Sharp HealthCare	<b>San Diego</b>	California
Sinai Health System	<b>Chicago</b>	Illinois
St. Mary's Health System	<b>Lewiston</b>	Maine
St. Vincent Healthcare	<b>Billings</b>	Montana
University of Vermont Medical Center	<b>Burlington</b>	Vermont
WNC Health Network	<b>Asheville</b>	North Carolina

A collaborative approach is key to building a Culture of Health—that is, creating a society that gives all individuals an equal opportunity to live the healthiest life they can, whatever their ethnic, geographic, racial, socio-economic or physical circumstance may be. These case studies highlight communities that are developing, implementing and sustaining effective strategies and successful programs to achieve that goal.

# Atlantic Health System

## Morristown, New Jersey

### Community Description

Atlantic Health System, a six-hospital system, has headquarters in northern New Jersey in Morristown, about an hour outside of New York City. The health system's service area of northern New Jersey and Pike County, Pennsylvania, is home to more than 2 million people. This community is highly educated: 93 percent are high school graduates, and 42 percent hold at least a bachelor's degree. The population is diverse: 27 percent are Hispanic/Latino, 12 percent are black or African-American, and 25 percent are foreign born. Though the region has areas with high levels of affluence, there are many pockets of socio-economic need and health disparities. About a third of the community's residents have demonstrated struggles to make financial ends meet.

The Community Engagement and Health Improvement Department is the engine that drives the health system's partnerships and community health improvement work. Consisting of Community Health, the Center for Faith and Health, and the Atlantic Center for Population Health Sciences, the department builds on a long-standing tradition of community health improvement work at Atlantic Health. The health system undertook an intentional

journey from a plethora of 144 community programs that were not evidence based, targeted or evaluated and streamlined them into three signature community health improvement programs across the system that are targeted, evaluated and evidence based. Each geographic region of the system is responsible for implementing its own projects to maintain local flavor and culture and address local concerns. Underpinning all this work are the community-based collective impact model, community-based participatory research and a desire to build community capacity. Additionally, the department is using its robust data resources to drive decision-making around population health management across the organization.

Atlantic Health System uses a three-pronged approach toward achieving its vision of improving lives and empowering communities through health, hope and healing:

1. Prevent illness and disease through community investment around socio-economic indicators and preventive services
2. Engage the community and develop strategically aligned partnerships
3. Optimize health care delivery and accessibility



Photo courtesy of Atlantic Health System

This commitment to building a health system Culture of Health is evident in how the system's hospitals operate. Leadership and clinical staff recognize that addressing the social determinants of health in partnership with the community is the only way to truly improve health. For example, the health system's nursing staff is engaged by integrating community health into clinicians' professional development pathway. Regional diversity councils lead many initiatives, including programming to expose staff from across the organization to a poverty simulation session, helping them understand the challenges of living in poverty.

# PRIORITY NEEDS

Obesity



Access to behavioral health care



Substance use disorders  
(heroin/opiate use)



Diabetes | Cardiovascular disease



## Community Partnerships

### North Jersey Health Collaborative

The North Jersey Health Collaborative (NJHC) serves as the backbone organization for regional health improvement. It was founded in 2013 by a group of nine organizations, including Atlantic Health System; since that time the NJHC has expanded to five counties — Morris, Passaic, Sussex, Union and Warren — with more than 125 organizational partners, including health care systems, public health organizations and community-based organizations. The collaborative's core function is to lead the community health needs assessment and implementation strategy process for the region; by connecting these different parties, all partners can strategically work together on community health improvement.

As part of a collaborative effort, community-identified health needs were prioritized and selected by each county. Workgroups are formed for each priority issue to align indicators and strategies. The collaborative's web portal ([www.njhealthmatters.org](http://www.njhealthmatters.org)) houses and

shares national, state and local health data, with up-to-date information and performance measures on each county's community health improvement plan, as well as a robust resource library to support community health efforts.

The NJHC is led by a board of trustees comprised of four officers, more than 20 funding partners, and the chairs of the regional Data Committee, Communications Committee, Finance Committee and local county committees. The board provides regional oversight, while the local county leadership and members have ownership and accountability for their county-specific community health improvement plan.

From the outset, the collaborative has been jointly funded and sustained by the participating organizations, through financial support and/or the donations of in-kind hours and resources, fostering a sense of communitywide buy-in. As an active participant in each of the NJHC workgroups, Atlantic Health leads several initiatives (described here, called "Signature Programs") addressing these priority health needs.

The Community Engagement and Health Improvement Department at Atlantic runs three systemwide community health improvements, geared toward meeting the needs identified in the collaborative's community health needs assessment.

## Atlantic Healthy Schools

Atlantic Healthy Schools brings together health care professionals and schools with the goal of improving the health of all students. The Atlantic Healthy Schools program provides resources, grants and technical assistance to more than 200 schools in northern New Jersey. Atlantic Healthy Schools operates with a “whole school, whole community, whole child” model. This model, developed by the Centers for Disease Control and Prevention, is a coordinated approach that integrates healthy policies and practices into schools to strengthen learning and health. Developing healthy habits in kids can set them up for a lifetime of good health.

Age-appropriate programs address healthy eating and healthy lifestyles. Programs are directed at children and their parents, and professional development opportunities are provided for staff and administrators. Additionally, Atlantic Health System has funded school-based fitness equipment and physical education teacher training for more than 30 schools via Project Fit America, with measurable increases in student physical fitness and school capacity.

A+ Challenge: Actions for Healthy Schools initiative provides technical assistance and funding for schools to make policy and environmental changes that increase opportunities for physical activity and improve nutrition.

Another program of note is Altitude, a youth empowerment/behavioral health program by and for adolescents, specifically eighth graders. Participants create posters and video and radio commercials, developing and implementing these media messages for their peers. They are also given the chance to lead service projects within and around their schools. The learning and impact continue beyond eighth grade as the adolescents enter high school and show increases in volunteer service. This program is measuring pre- and post-test results, conducting focus groups at the participating schools and conducting element-by-element evaluations.

## Healthy Communities

The Healthy Communities initiative supports the elimination of health disparities as part of its disease prevention and health promotion efforts.

- Culturally specific health outreach. Provides education and community-based care

coordination for individuals and families. One example is Atlantic Health’s work with partners at the local First Baptist Church of Madison to share health information with parishioners and foster a healthy church environment. Using emergency department and public health data, the team identified four neighborhoods with high disparities in chronic disease. The Neighborhoods Initiative is building community partnerships, identifying resident-defined priorities and working toward shared issues.

- Community-based partnerships to address health disparities in four local, low-income target communities
- Environmental and policy change by building capacity of community partners. In partnership with the New Jersey Department of Health, New Jersey Partnership for Healthy Kids, Salem Health and Wellness Foundation, Partners for Health Foundation and New Jersey YMCA State Alliance, Atlantic Health System awards upward of \$375,000 per two-year grant cycle via the New Jersey Healthy Communities Network (NJHCN) community grants program. The purpose of the NJHCN’s community grants program is to provide funding and technical assistance to New Jersey communities to enhance the built environment and advance policy to support healthy eating and active living. The goal is to modify settings – whether they are community-based spaces, schools, or workplaces – so that the healthy choice is the easy one. Grantees are awarded \$20,000 over two years; they also receive technical assistance including individual coaching and regional and statewide meetings. Examples of funded projects include creating community walking paths, passing Complete Streets policies and improving access to fresh produce via farmers markets and community gardens. Funding is awarded with special attention to communities that face socio-economic barriers to health.

## New Vitality

New Vitality is an inventory of health and wellness services for older adults designed to prevent age-related chronic conditions and disabilities and minimize hospitalizations. Participants receive a health risk assessment and health coaching and are connected to a variety of exercise and nutrition opportunities. The program is now working directly with physicians to refer patients suffering from chronic disease into community-based resources.

## Impact

New Jersey Health Collaborative performance measures (January – July 2017)

- Average number of organizations participating per month: 145
- Member perception of value of participating in NJHC (mean score, range 1-7): 6.2
- Member perception of value of participating in topic-based workgroup (mean score, range 1-7): 6.2
- Member perception about having the “right people” for collaboration (mean score, range 1-7): 5.6
- To see strategies and performance measures by county and workgroup, visit Plans & Priorities at [www.njhealthmatters.org](http://www.njhealthmatters.org)

Atlantic Healthy Schools performance measures (2016–2017 school year)

- Number of member schools: 227
- Member satisfaction with in-class programming (mean score, range 1-5): 4.7
- Member satisfaction with professional development opportunities (mean score, range 1-5): 4.8
- Number of policy, system and environmental changes made via A+ Challenge (pilot year, 7 schools): 11

Healthy Communities performance measures (January – July 2017, unless otherwise noted)

- Number of residents/organizations active in Neighborhoods Initiative (4 community-based partnerships): 68
- Direct monetary investment in targeted, community-based partnership and policy, system and environment change (2015–2016, reflects grant cycles): \$475,000

New Vitality performance measures (2016)

- Number of participants: 8,582
- Participant satisfaction with New Vitality programming (mean score, range 1-10) : 9.58

## Lessons Learned

Support from the top allows for integrating a Culture of Health into the organization itself and its core mission. The community must own health initiatives, not the health system. The Atlantic Health System CEO, Brian Gragnolati, articulated that the organization needs to move toward a mindset of the “community taking care of the community.” Understanding of and buy-in for community health initiatives by senior leadership is necessary for health improvement.

It is important to build a systemwide infrastructure that streamlines the work to focus on what the hospital or health system knows works best to meet community health needs. Atlantic Health focused on three signature programs across the system, enabling a level of standardization systemwide while also enabling local-level “translation” based upon community culture. This systems approach to community and population health appears to be a successful model for systems.

Integrating community health activities into clinical departments in the hospitals can help break down silos. Atlantic Health is using population health and its ACO to drive spread of community health improvement work through clinical departments. This requires a paradigm shift that includes new skill sets, staff buy-in, leadership and flexibility to effectively transition community work into a population health model.

Having the North Jersey Health Collaborative lead the community health needs assessment process demonstrated that the assessment was by and for the community, not just for the health system. This model collaborative fostered new partnerships that have continued beyond the scope of the assessment.

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## Baltimore, Maryland

### *Community Description*

#### Story

Baltimore, a “city of neighborhoods,” is a large metropolitan seaport city on the East Coast. LifeBridge Health is a regional health care organization based in northwest Baltimore and its surrounding counties, with hospitals serving urban (Sinai Hospital of Baltimore, Levindale Hebrew Geriatric Center and Hospital), suburban (Northwest Hospital) and rural (Carroll Hospital) communities. This four-hospital system is one of the largest community hospital systems in the region and has invested significantly in the community and in community engagement. The health system focuses on the whole patient and life circumstances and not just the patient’s disease, which is reflected in LifeBridge Health’s extensive network of community health workers and other care coordination staff.

Maryland is the last of the “waiver” states in the nation, having opted out of a Medicare fee-for-service payment system in the 1970s in favor of an all-payer model, which allowed for equity of health care costs across all insurers and other payers. The waiver currently involves a five-year experiment with a value-based payment model called the global budget revenue (GBR) system. Hospitals receive a fixed sum payment for all Medicare patients for the year, which incentivizes reduced utilization of acute health care services. This has a great impact on how hospitals strategically care for their patients. There is clear focus and devotion to preventive care, care coordination and community investments as a fundamental practice for the hospital.

The region is data rich due to its statewide health information exchange (HIE). The Chesapeake Regional Information System for our Patients (CRISP) HIE enables health care providers to transfer data through electronic networks among disparate health information systems. The HIE is built for interoperability to communicate health data among Maryland physicians, hospitals, other health care organizations and providers. It also enables communities with regional HIEs to connect with other communities around the state. The HIE has an event notification function that indicates to a provider if a patient accesses care anywhere in the state, allowing for sophisticated care coordination and continuity.

#### Population

According to the 2015 community health needs assessment (CHNA) for Sinai Hospital of Baltimore, part of LifeBridge Health:

- The community’s population is approximately 60 percent black/African-American, 30 percent white and a small percentage Asian-American or “Other.”
- Average household size is 2.46 people.
- Estimated median household income is \$54,594.
  - » Income less than \$15,000 (below federal poverty limit): 14.6 percent of population
  - » Income between \$15,000 to \$34,999: 19.2 percent of population

# PRIORITY NEEDS

Looking at geographic mapping for mortality within the city of Baltimore, the northwest region of the city has the strongest concentration of high incidences of infant mortality and the lowest life expectancies, compared to neighboring communities (see maps on page 12). Other challenges with social determinants of health characterize the community that LifeBridge

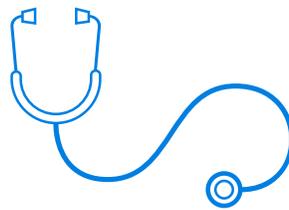
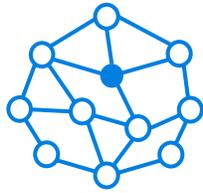
Health serves, including lower income levels, lower educational attainment, vacant housing and higher levels of incarceration and violence. During the 2015 CHNA survey for Sinai Hospital, 30 percent of respondents answered "violence" to the question "What do you think causes the most deaths in your community?"

The top priority needs listed in the 2015 CHNA for Sinai, Levindale and Northwest hospitals are:

Violence

Diabetes

Heart disease

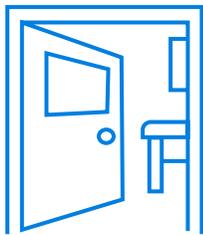


The top priority needs listed in the 2014 CHNA for Carroll Hospital are:

Health care access

Physical health status

Mental and behavioral health



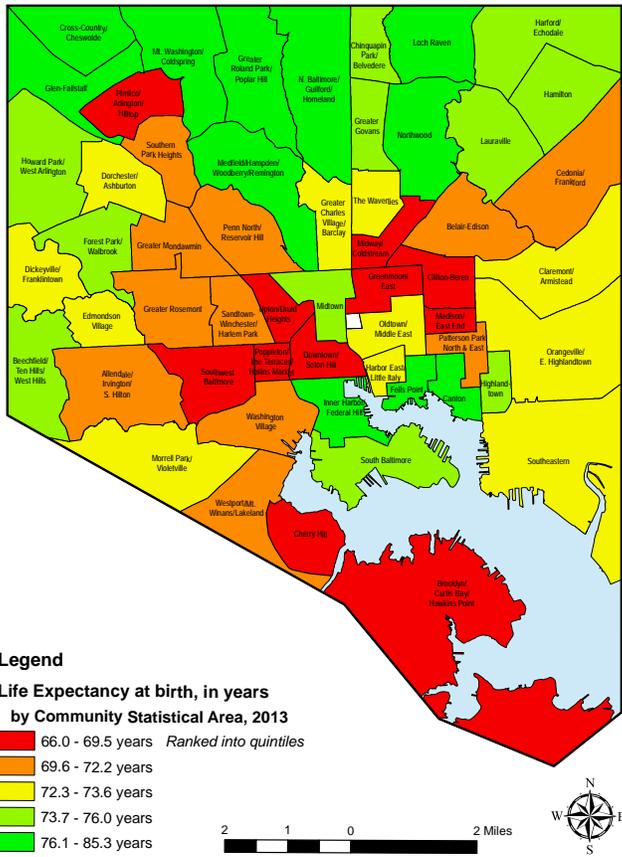
Chronic health conditions

Preventive health practices

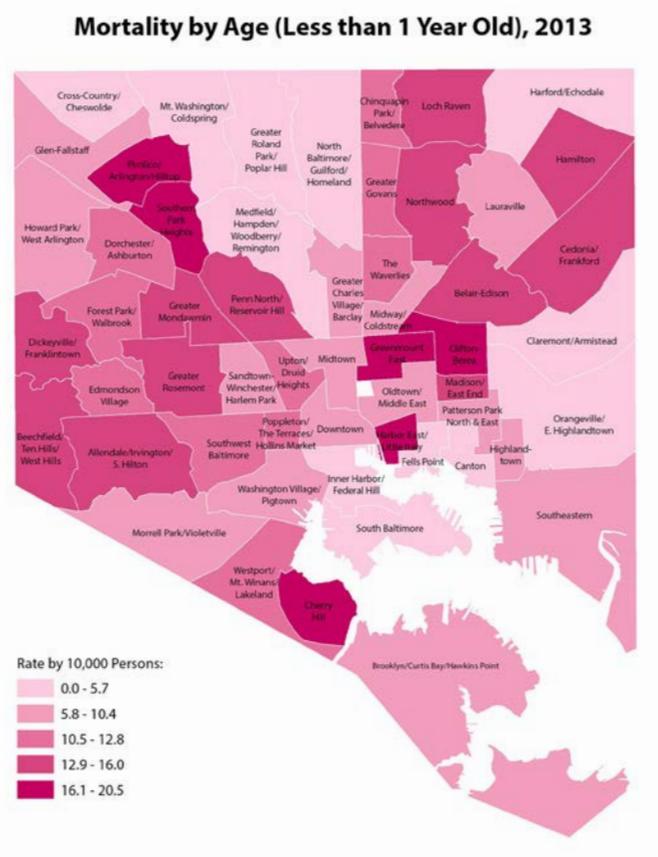
Social determinants of health



# Baltimore City Life Expectancy by Community Service Area and Baltimore City Mortality by Age (Less than 1 Year Old), 2013



Prepared by the Baltimore City Health Department.  
 2013 Life Expectancy data provided by DHM's Vital Statistics Administration.



## Community Partnerships

### Violence Prevention: Kujichagulia Center

In partnership with the Baltimore City Health Department and the Office of Youth Violence Prevention, LifeBridge Health is committed to interrupting the cycle of violence in the Sinai Hospital service area. Recognizing that violence has an enormous impact on the health and wellness of individuals and especially youth, this program uses

evidence-based public health and human service models to identify and intervene when an act of violence occurs.

The city's Safe Streets program employs ex-convicts as violence interrupters (VIs), providing job opportunities that are often hard for this population to obtain. VIs are trusted members of the community and provide a voice for the victims and perpetrators.

On the hospital side of the partnership, Sinai's Kujichagulia Center employs hospital responders who meet victims of violence in the emergency department and inpatient units, to learn more about the conflict and determine what dynamics led to the incident – and whether retaliation is imminent. If retaliation seems likely, the hospital responder contacts the Safe Streets team in the patient's neighborhood to mediate a conflict.

Further, the hospital responders engage the victims by connecting them to workforce readiness and life skills mentoring, a program Sinai offers out of its

Community Initiatives office. This partnership has received a unique source of support through the Health Services Cost Review Commission (HSCRC), Maryland's rate-setting and regulatory body for hospitals. When the HSCRC awarded a series of grants statewide to stimulate hiring of entry-level health workers in disadvantaged neighborhoods, it included an extra package of funding to expand the Safe Streets partnership with Sinai Hospital. This expansion included funding a second Safe Streets post within Sinai's service area, including a new office and three new VIs, as well as a fully staffed team of hospital responders and a new social worker to further engage clients in the recovery and workforce engagement process.

### Community Health Workers: Diabetes Medical Home Extender Program, HIV Support Services Program, Family Violence Program

#### **Diabetes Medical Home Extender Program**

is a home-visiting program for patients identified in the hospital with uncontrolled diabetes. A social worker, nurse and community health worker provide assessments, service coordination, education, psychosocial support, information and referral to assist clients in managing their diabetes.

**HIV Support Services Program** is a home-visiting program for HIV-exposed infants, HIV-positive adolescents and HIV-positive adults meeting Ryan White eligibility criteria. A social worker and community health workers provide psychosocial assessments, service coordination, advocacy, education, information and referral, case management, wellness series and support groups.

**Family Violence Program** is a crisis intervention program for victims who come to the Sinai emergency department. A social worker and community health worker (CHW) provide danger assessments, safety planning, individual and group counseling, service coordination and home visits. Consistent check-ins, guidance and time spent with community health workers help clients establish deep connections and trusting relationships with their CHW.

### Home Maintenance: HUBS (Housing Upgrades to Benefit Seniors)

Housing Upgrades to Benefit Seniors (HUBS) is a citywide program started by Civic Works and funded

by the Leonard and Helen R. Stulman Charitable Foundation and the Hoffberger Foundation. In 2015, Sinai Hospital of Baltimore received a grant from Civic Works to become the HUBS service site for Northwest Baltimore.

The program assists adults age 65 and older to remain safely in their homes. The HUBS social worker at Sinai reaches out to clients over the phone and through home visits to determine what their needs are. Repairs and upgrades are prioritized based on what is most important to the homeowner, unless there is an immediate safety issue that must be addressed. The social worker helps clients determine the best course of action for getting the work done following a home visit. When clients are referred to various city programs that provide repairs, the social worker will help them fill out applications and gather the necessary documents. Clients also receive help applying for grants or loans or both to cover the costs of repairs and upgrades.

### Perinatal Mental Health

Initiated by a staff member in the 1990s, Sinai Hospital's Perinatal Depression Outreach Program (PDOP) is the only hospital-based program of its kind in the state of Maryland. The program is dedicated to helping women understand the emotions that can accompany pregnancy and the postpartum period. Due to a lack of available maternal mental health practitioners, the program also promotes educational opportunities.

One such opportunity is the Baltimore Perinatal Mental Health Professional Study Group. This group provides a unique opportunity for multidisciplinary professional connection, development and support of one another. Study group participants represent professionals invested in perinatal mental health, including therapists, psychiatrists, obstetrics providers, lactation consultants, doulas, support group facilitators, public health professionals and researchers. Meeting space is provided by Sinai Hospital of Baltimore, and the meetings are held four to six times a year.

### ED Navigation Program

Launched in June 2014, Access Health was a partnership between Sinai Hospital and the Baltimore nonprofit organization HealthCare Access Maryland. The program addressed health disparities, reduced admissions and readmissions, and expanded primary

care capacity by increasing health care access points, promoting continuity of care efforts and diverting frequent emergency department visits. It accomplished this by embedding three care coordinators in the hospital's ED during day, evening and weekend hours. It was designed to capture patients who were high utilizers of emergency services or at risk for pregnancy complications, and then linked them to appropriate, health-promoting care and follow-up resources. The program produced such successful results that both Sinai and Northwest hospitals decided to incorporate the model into a larger community care coordination structure, working across the navigation spectrum from inpatient to ED to doctors' offices and clinics. Through the development of this comprehensive approach, LifeBridge Health decided to fund its own internal team to provide these services.

Key elements include:

- Warm handoffs to coordinators in the ED
- CRISP statewide encounter notification alerts to the provider through the electronic health record
- Coordinators who are certified application counselors
- Risk stratification of clients

## Maryland Faith Health Network

Based on the Congregational Health Network in Memphis, Tennessee, this pilot network of Maryland churches provides community support for congregants during and after a hospital stay at Sinai, Northwest or Carroll hospitals. LifeBridge Health's span across urban, suburban and rural areas made the organization an ideal partner with the Maryland Citizens' Health Initiative in seeing how the model could play out in these various contexts. Support for congregants may mean hospital visits from clergy or other liaisons, meals, rides to follow-up appointments



Photos courtesy of LifeBridge Health

and other postdischarge support. The network is made up of existing communities to help build a support system around wellness and health. For consenting individuals, the hospital notifies someone in the church congregation when an individual is admitted to the hospital.

The program also offers free health resources to promote health in the community. The care coordination that results from this network provides patients with a support system that can aid in better managing their care and general assistance during a time when individuals are most vulnerable. Throughout the two-year pilot phase of the program, Carroll Hospital's rural, tight-knit environment facilitated especially great successes in identifying congregants when they came to the hospital and connecting them back with their pastors and communities. LifeBridge Health facilities continue to invest in this model through dedicated staff time; shared implementation of health education programming; shared strategic action in reaching new communities, such as the Orthodox Jewish community surrounding Sinai; and other system improvements aimed at a smooth hospital-to-home transition. In the two-year pilot, the network grew to more than 1,600 individual members.

## Impact

- Since 2013, the Diabetes Medical Home Extender Program has offered in-home diabetic support to more than 150 clients. Participants have seen a significant reduction in inpatient hospitalizations (over 68 percent) resulting in more than \$1.24 million in savings to the health system.
- During fiscal year 2016, the HIV Support Services program supported nearly 400 HIV-positive



individuals with intense support and case management. Because of this team's efforts, 91 percent of clients have maintained an undetectable viral load, reducing their risk of becoming ill and the likelihood of transmission.

- During fiscal year 2016, the Kujichagulia Center has supported more than 30 clients, providing workforce readiness and life skills training in an effort to break the cycle of violence plaguing the youth in neighborhoods surrounding the hospital. As a result of participation, more than half of those clients were hired by LifeBridge Health facilities or other community organizations, further enhancing the opportunities for these youth. A middle school mentoring portion of the Kujichagulia Center provides mentoring for approximately 120 young men per school year.
- Since September 2015, the Housing Upgrades to Benefit Seniors program has served more than 280 clients (most of whom fall below the 50th percentile of the Area Median Income), providing home safety assessments and enhancements, handyman services, and referrals to citywide housing resources. To date, almost 200 homes (89 percent of the three-year goal) have been serviced for clients, including installation of supportive hand railings, stairway repair, roof repair, furnace replacements and more.
- As of March 2016, the ED Navigation Program, with 524 clients enrolled, has reduced emergency department visits 64 percent (157 avoided visits) and reduced inpatient stays 80 percent (54 avoided visits). In addition, 150 people signed up for health insurance, and 260 clients obtained a primary care provider, with 73 percent keeping their appointments.

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## Lessons Learned

Statewide health information exchange allows for communication and coordination among and between hospitals, which helps to provide accountability for all organizations making an effort to improve patient outcomes.

Community health workers form the backbone of many of LifeBridge Health's most successful efforts to support patients and clients in managing their diseases and addressing social determinants of health. The relationships, resources and support that CHWs bring to the nonclinical health care environment have great impact on a systematic level for the hospital and health outcomes, and also at a personal level for patients in the community.

Grant-funded partnerships and innovative nonprofit programs serve as a proving ground for ideas that can end up showing a return on investment for hospitals – which then can lead to hospital decisions to fund the same or similar programs out of their own operating budgets.

Programs focused on addressing social determinants of health have the ability to produce short- and long-term effects on high-priority hospital measures such as volume of inpatient admissions, and public health measures such as HIV viral loads.

Hospitals' speed and agility in building programs falls somewhere in the middle between small community organizations and large municipal operations. For example, CHAI (Comprehensive Housing Assistance, Inc.) was able to nimbly expand its senior home repair program model to accommodate the HUBS program fairly easily; Sinai built the social work piece of the program but could not quickly invest in a handyman component; and the city of Baltimore experienced delays in processing applications through a central point as it worked to build its capacity across five sites throughout the city. Partnerships should consider these and other strengths or limitations of participating organizations based on size, resources, level of bureaucracy and other factors.

# Seton Healthcare Family

## Austin, Texas

### Community Description

#### Story

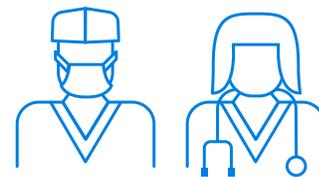
Austin, the capital of Texas, is one of the fastest growing cities in the United States. It is home to many artists, musicians and people working in technology, including a high concentration of millennials. Austin is known for its music scene and eccentric and artistic residents. The population is growing extremely quickly in Austin, Travis County and Central Texas overall. From 2000 to 2010, Central Texas' population grew by 37 percent, which is nearly four times faster than the national average. This change has resulted in the population growing faster than infrastructure and resources that can support a healthy region, including access to transportation, food and educational opportunities. In addition, access to health insurance and affordable health care are insufficient, and five counties in the region are designated by the Health Resources and Services Administration as medically underserved areas.

#### Population

- Travis County includes Austin, Pflugerville and many smaller suburban communities. In addition, the region contains several of the country's fastest growing suburban cities.
- Travis County has a growing Hispanic population. Hispanics currently make up 35 percent of the population in Travis County and are projected to compose 40 percent of the population by 2030.
- Despite the influx of younger workers to Austin, the number of adults 65 and over is expected to grow from 101,489 in 2016 to 187,459 in 2030, an 85 percent increase.
- In 2015, Austin had an estimated population of 931,830.
- In 2016, the population of Travis County was estimated at 1,129,582 and is projected to grow to 1,342,829 by 2030, a 19 percent increase.
- In 2016, the population of Greater Austin, the five-county surrounding metro area, was estimated to be 2,056,405.

## PRIORITY NEEDS

Mental and behavioral health | Chronic diseases | Primary and specialty care



System of Care | Social determinants of health



# Community Partnerships

## Integrated Delivery System: Community Care Collaborative

The mission of the Community Care Collaborative (CCC) is to develop an integrated health care delivery system for uninsured and underinsured Travis County residents living at or below 200 percent of the federal poverty level.

The CCC is a nonprofit organization established by Seton Healthcare and Central Health in 2013 to provide a unified system approach to safety-net health care. By aligning Seton's hospital-based system with Central Health's primary care-based network of providers, the CCC is able to improve patient outcomes and the efficiency of care. As a result of the CCC partnership, hospital systems now care about how patients are managed in the primary care system and vice versa.

The CCC partners with many local organizations, including local universities, federally qualified health centers, community-based social service agencies and other health care partners. The CCC is working with its contracted providers to gather better patient data and analysis, and better understand the health needs of the entire population.

Seton provides financial and health care support and Central Health, Travis County's health care district, provides financial support to the CCC. The CCC is focused on developing an integrated delivery system to:

- manage care coordination;
- upgrade technology;
- improve system efficiency; and
- focus on illness prevention, disease management and health promotion.

## Education for Providers: Dell Medical School

In 2011, Sen. Kirk Watson, D-Austin, a former Austin mayor, shared a vision of "10 Goals in 10 Years" to help transform the health and economy of Travis County. Travis County voters supported this vision and in 2012 approved a proposition with a property tax increase to support Watson's goals.

The first goal in this vision created Dell Medical School, which opened in July 2016 at The University of Texas at Austin (UT Austin). One provision within the proposition ensured that Dell Medical School would help Central Health boost the community's overall health by expanding access, improving care and lowering costs. Dell Medical School relies on locally generated tax revenue as well as an annual transfer of \$35 million from the Community Care Collaborative, the result of a 2014 affiliation agreement with Central Health.

The affiliation agreement between UT Austin and Seton outlines how faculty members, residents and students at the Dell Medical School work, train and learn at Seton facilities, including a new \$300 million state-of-the-art teaching hospital, which supports the second goal outlined by Watson. Seton has financially supported graduate medical education in Austin since 2005, through a series of affiliation agreements, first with UT Medical Branch in Galveston, UT Southwestern in Dallas, and then UT Austin and the Dell Medical School. As part of an affiliation agreement with UT Austin and the UT System, Seton committed to continue its substantial financial support for the residents, faculty and overhead of the new medical school.



## GIS Mapping: Children’s Optimal Health

In 2008, Seton led an effort, along with 12 other community agencies and organizations in Austin, to create Children’s Optimal Health (COH). These partners reflect the diverse organizations that affect outcomes for children including health care, housing, education, economic development and social and emotional development. This collaborative approach allows the members to take a closer look at determinants of health and the disparities in access to health care and social services that are creating significant barriers to the health and well-being of children and their families.

The mission of COH is to use geographic information system mapping to help communities visualize the health of their neighborhoods, identify assets and needs and discover opportunities for collaborative change. The purpose of these efforts is to:

- Improve operations
- Influence policy
- Encourage research
- Mobilize the community

A geographic information system (GIS) and related spatial analysis methods are instrumental tools for describing and understanding changes in a community’s landscape, including the delivery and utilization of health care services. As visual images, maps can overcome language barriers and offer a powerful communication tool. COH utilizes GIS to map proprietary, de-identified data acquired through data-sharing agreements with more than 14 Austin area education and health entities. The ability to use individual residence data allows COH to create neighborhood maps and identify concentration areas known as hot spots (see map in column 2).

Once hot spots are identified, COH can create drill-down maps and take a closer look at contributing factors. Community asset data (such as food, schools, parks, health care and transportation), demographic data (such as socio-economic status and race/ethnicity) and other community characteristic data (such as crime rates) can be overlaid, giving a fuller picture of both positive and negative contributing factors.

# The ability to use individual residence data allows COH to create neighborhood maps and identify concentration areas known as hot spots.



All maps are approved by an expert Scientific Advisory Committee made up of physicians, school officials, direct service providers, researchers and academics, and the data owners.

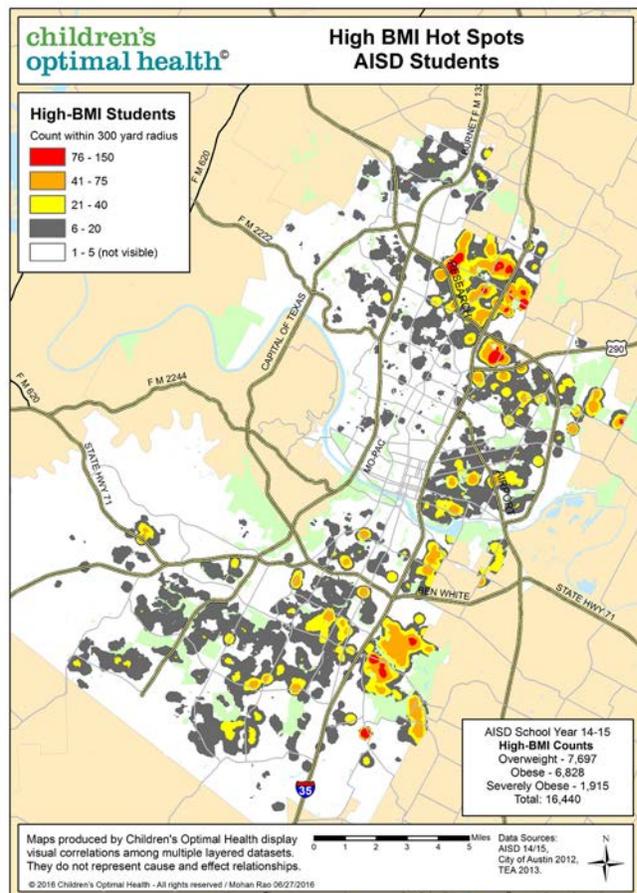


Image courtesy of Children’s Optimal Health

The maps provide a data-driven picture easily understood by a wide variety of audiences. Topics analyzed have included obesity, behavioral health, substance abuse, asthma and child injuries related to transportation, child maltreatment and housing. The COH collaboration results in breadth, depth and quality that is cross-cutting across contributors to health and well-being, as well as across service providers. The maps provide an evidence-based representation that can be easily understood by all and which have been used to stimulate targeted action, support service providers with information that can be incorporated into grant funding proposals, and evaluate and monitor interventions.

Once projects are completed, a community summit is held in most cases to present the information to the community and engage action partners in the planning process for prevention and intervention for a given neighborhood. Community summits bring together subject matter experts, parents, educators, health and social service providers, neighborhood advocacy groups and others to find solutions and determine next steps for action and implementation.



Photo courtesy of Seton Healthcare

## Seton's Clinical Education Center: Skills and Simulation Lab

As the largest simulation facility in Central Texas, Seton's Clinical Education Center (CEC) plays a critical role in health care education. The CEC includes a hands-on simulation environment that provides opportunities for nurses, physicians and other medical professionals to experience real-life hospital settings. Some of the features that make the facility unique are the interactive mid- to high-fidelity manikins, rooms with audio and visual capabilities and more than 150,000 square feet of education space.

The goal of the CEC is to expand medical education, improve patient outcomes and provide collaborative education opportunities. Seton's simulation lab includes four 10-bed skills labs, eight group simulation labs, four debriefing rooms, 12 training rooms, two computer labs, one simulated hospital unit with 22 total individual patient rooms, two exam rooms and a medical library.

The Clinical Education Center is the result of an academic collaboration with Seton, Austin Community College, Concordia University, Texas Tech University, the University of Texas at Austin and other community partners. Students and clinicians regularly use the simulation lab to reconstruct the concept of deliberate practice of medical skills before delivering patient care.

In summer 2016, the CEC created the Seton Health Sciences Interactive Camp to provide an opportunity for middle school and high school students to learn about careers in health care. During this interactive camp, participants engage in hands-on clinical simulation and can become certified in cardiopulmonary resuscitation (CPR). In June 2017, more students participated in this exciting, hands-on experience. The goal is to prepare tomorrow's health care professionals today.

## Impact

- The Community Care Collaborative formalized a plan for coordination of the integrated delivery system and initiated work outlined in the plan. The CCC also initiated development of a new benefits plan for low-income residents (up to 375 percent of the federal poverty level) in Travis County.
- In 2016, Children’s Optimal Health continued work with Dell Children’s Medical Center by mapping reports of child maltreatment. COH has continued assessment mapping and metrics for the Go! Austin/Vamos! Austin programs. COH completed mapping of 2014-2015 Austin Independent 33 Community Collaboration School District, completed obesity projects for the Pflugerville Independent School District and Round Rock Independent School District, and held a summit in collaboration with the Youth Substance Abuse Prevention Coalition.
- The collaboration to create a new medical school, teaching hospital and health innovation district is estimated to create 16,000 new jobs and provide a lift of \$2 billion to the local economy.

## Contact

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## Lessons Learned

Collaboration can transform a fragmented approach into one that is person centered, less costly and of high quality.

The Community Care Collaborative understands the importance of shared risk among stakeholders, and leverages the sharing of risk to bring collaborators together and incentivize them to work together to accomplish expansive and ambitious goals.

Combining data from multiple sources and sectors can leverage information for the community’s benefit in ways no single member organization can. The insights gathered by analyzing data from multiple sources can also help organizations improve their effectiveness in delivering services that significantly improve the health of the community’s population.



**The collaboration to create a new medical school, teaching hospital and health innovation district is estimated to create 16,000 new jobs.**



# Sharp HealthCare

## San Diego, California

### Community Description

#### Story

San Diego County is the second largest county in California, with a population of 3.2 million people. It is a diverse region, with 33 percent of the population identifying as Hispanic. San Diego County borders Mexico to the south. The population is expected to grow more than 4 percent in the next five years, with the highest population growth among those over 65 years of age. While San Diego is generally known for its temperate weather and beautiful beaches, the region also faces significant rates of poverty and homelessness.

Sharp HealthCare (Sharp) is a not-for-profit, seven-hospital health care system located in San Diego County, serving the entire region. It is the primary safety-net system for the region. An integrated system, Sharp is the largest private employer in San Diego, with four acute care hospitals, three specialty hospitals and 22 primary and specialty clinics. Sharp also has a health plan with 136,000 members. The health care system has 29 percent of market share in San Diego County and 35 percent of Medi-Cal market share in the region.

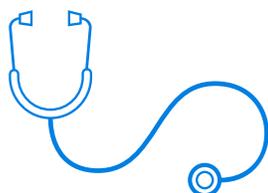
#### Population

Sharp Grossmont Hospital serves the east region of San Diego County, and approximately 5 percent of the population lives in remote or rural areas. The per capita income of San Diego County's east region is lower than the county overall, and this region also has the highest population of residents over 65 years of age. Sharp Grossmont Hospital, a 528-bed hospital, has one of the busiest emergency departments in San Diego County, with nearly 107,000 visits annually. In fiscal year 2016, Sharp Grossmont Hospital spent \$98.5 million on community benefit programs and services. Approximately 41 percent of patients are on Medi-Cal.

Food insecurity is a significant problem in San Diego County, with 13 percent of the population qualifying as food insecure. This means 1 in 8 San Diegans and 1 in 5 children qualify as food insecure.

## PRIORITY NEEDS

Mental and behavioral health | Cardiovascular health | Diabetes (type 2) | Obesity | Senior health



# Community Partnerships

Sharp Grossmont Hospital recognizes that the health and social needs of its community are intertwined, and that to improve health it needs to build a network of services and providers around its most vulnerable patients. The hospital does this through its Care Transitions Intervention (CTI) program, which includes multiple internal and external partnerships. Especially strong collaborations are with two primary partners: 2-1-1 San Diego and Feeding San Diego.

## 2-1-1 San Diego

2-1-1 San Diego is a resource and information hub that connects people with health and social services. 2-1-1 San Diego evolved from the United Way of San Diego County's information and referral program, INFO LINE, which originated in the 1970s; eventually the Federal Communications Commission designated the 2-1-1 dialing code for community information centers across the nation, allowing INFO LINE to secure the three digit dialing code to become a public utility. 2-1-1 San Diego, using an entrepreneurial approach, provides a more robust level of services and assistance than is typically offered by information and referral organizations. Available 24/7 with a web database and contact center, 2-1-1 San Diego assesses for needs and then connects individuals with closed-loop referrals to housing, health, food and other services for which they may be eligible. 2-1-1 San Diego has a staff of 130 who are able to respond to questions in more than 200 languages.

2-1-1 provides service in three tiers depending on the needs of the individuals:

1. General information and referral
2. Information and assistance (e.g., benefit enrollment services—secures electronic and telephonic signatures to speed up application completion)

3. Care coordination for vulnerable populations, including military members and veterans, people with chronic health conditions, and those with complex barriers to access

This tiered approach and responsiveness to community needs allows 2-1-1 San Diego to provide person-centered services. 2-1-1 San Diego maintains records for each person who dials in, so they have consistent records about their clients and can do a deeper level of care planning and provide individualized referrals and track progress. Recognizing it cannot measure success by the number of calls, 2-1-1 San Diego does closed-loop referrals to know the outcome of the referrals.

2-1-1 San Diego is also innovating how it does its work. For example:

- Handles screening and enrollment by phone for SNAP/CalFresh benefits
- Sends out healthy eating outreach postcards, then follows up with an outbound dialing campaign
- Has breast health specialists among the referral staff to screen for mammograms
- Includes new screening questions so people can be referred to other programs for which they may be eligible, such as health care coverage
- Spearheads social service client information data-sharing technologies

## Feeding San Diego

Established in 2007, Feeding San Diego is the leading hunger-relief organization in the county, providing 21.2 million meals in 2016, and it is the only Feeding America affiliate in the region. Feeding San Diego provides food and resources to a network of more than 225 distribution partners serving 63,000 children, families and seniors each week. Focused on healthy food, education and advocacy, Feeding San Diego is building a hunger-free and healthy San Diego through innovative programs and collaborative partnerships. Feeding San Diego is deliberately partnering with health care and hospitals around food insecurity.

Sharp Grossmont Hospital's Care Transitions Intervention (CTI) Program is the focal point of the collaboration with 2-1-1 and Feeding San Diego. Recognizing that they cannot achieve health without addressing the social determinants of health, the three organizations are working to bridge the gap between social services and health services for patients discharged from the hospital. The CTI model is based on a Center for Medicare & Medicaid Services (CMS)-funded program, the Community-based Care Transitions Program (CCTP). CCTP was a collaboration among four health systems—Sharp, UC San Diego Health, Scripps Health, Palomar Health—to stimulate “collaboration among competitors” as well as community nonprofits. The goal was to

manage care at home for Medicare fee-for-service patients after discharge. CCTP used an evidence-based coaching model and eventually added pharmacy and social services to the model. The goal was to reduce readmissions among the participating Medicare fee-for-service patients.

The success of the CCTP program led Sharp Grossmont Hospital to create the CTI program for its vulnerable patients of all ages. Because patients and family caregivers are essentially their own care coordinators, they need help – coaching – to get through all the coordination of transitioning to being at home and ensuring that they receive the resources to keep them healthy and out of the hospital. The hospital conducts patient risk assessments that include biometrics as well as the social determinants of health. Each patient is given a paper “personal health record” that includes questions about having enough food and transportation to appointments. CTI coaches are trained in motivational interviewing and advanced care planning.

Additionally, Sharp redesigned its revenue cycle team to include public resource specialists and financial counselors who meet with the patient within 24 hours of admission. Team members help patients procure what they need to apply for Medi-Cal and work with them until a decision is made; if need be, they help with the appeals process. The team developed a tool so that people can get “presumptive” approval for Medi-Cal and then get their medications after discharge from the hospital. Further, the Patient Financial Services team at Sharp Grossmont Hospital worked closely with the CTI program to evaluate patients for CalFresh/SNAP (Supplemental Nutrition Assistance Program) benefits prior to hospital discharge, dramatically increasing the likelihood that patients complete CalFresh applications and receive benefits. In fiscal year 2016, the team completed 227 CalFresh applications, and 125 patients were granted CalFresh



Photos courtesy of Sharp HealthCare



benefits. As a result of the success from the pilot, this model for dual Medi-Cal and CalFresh evaluation and enrollment has expanded to all of Sharp's acute care hospitals. As of March 2017, the Sharp health system has enrolled 209 patients and their eligible family members in CalFresh.

The CTI program relies on community partnerships to meet the needs of people at home once they are discharged from the hospital. In the past, the onus was on the patient to follow up on referrals after discharge; for CTI participants, 2-1-1 San Diego's Care to Community Connection program receives electronic referrals from providers and makes outbound calls to patients and reports back to Sharp. 2-1-1 San Diego has relationships with 1,200 service providers and maintains a robust database of services available across the region. Access to available resources, direct care planning and ongoing client support, technology infrastructure and closed-loop referrals are critical factors for program success. 2-1-1 San Diego leads the 360° Community Coordination platform, creating an ecosystem of service providers sharing information and outcomes to better coordinate care.

Many patients in the CTI program are food insecure. Especially upon hospital discharge, patients may not have access to nutritious foods necessary to maintain their health. Sharp Grossmont Hospital partners with Feeding San Diego to provide boxes of food to program participants in need. CTI coaches keep a box with medically tailored, nonperishable food items in their cars. Food boxes are intended to bridge the gap in food insecurity until a patient is connected to resources such as a food distribution site, or CalFresh (SNAP/food stamp) benefits. When coaches refer patients to Feeding San Diego, the organization follows up with the patient via an outbound phone call and evaluates them for CalFresh benefits. In addition, Feeding San Diego refers these patients to food distribution resources, whether or not patients are eligible for CalFresh benefits. Feeding San Diego works with the CTI coaches and sees potential to grow this work.

## *Impact*

Sharp Grossmont and 2-1-1 San Diego worked together to develop a risk-rating tool for patients. Risk is judged along a spectrum: crisis (intense difficulty, trouble or danger), critical (severe concern), vulnerable (at risk), stable (satisfactory state), safe (secure and able to manage difficulty), and thriving (ability to flourish). Clients were assessed along 14 domains of wellness: housing, nutrition, primary care, health condition management, social/community connection, activities of daily living, criminal justice/legal, income, transportation, personal hygiene, utilities, safety/disaster, education, employment. These dimensions are used to assess impact of the resources and coaching delivered through the Care to Community Connections program.

For the Care Transitions Intervention program in 2016:

Participants were more food secure:

- 13 percent of participants, or 526, identified as food insecure.
  - 36 percent referred to 2-1-1 reported decreased nutrition vulnerability.
- 69 participants received food bags; readmission rate of 7.2 percent and higher likelihood of keeping follow-up.
- 17 participants were evaluated for CalFresh and 8 confirmed approval via 2-1-1.

Participants had improved health self-efficacy:

- 95 percent of participants had decreased vulnerability on scale.
- 95 percent of participants were confident in their current plan to manage their health.

## Lessons Learned

Expanding the Care Transitions Intervention program requires a coordinated team effort that fosters internal and external partnerships. Many people in the hospital and community are working on different aspects of the same problem with a patient. Yet, as one leader noted, “There’s a glue that connects us.” CTI allows Sharp to be better coordinated and help patients get care managed outside of the hospital. As one CTI coach said, “I can do my job with confidence because I can connect with resources within the system.”

CTI works well at Sharp because leadership sets the tone. One hospital leader noted, “Patient trust is what we work on the most so [patients] know they are valuable.” Having organizational champions who can communicate to staff and the community with both vision and passion is key. Furthermore, everything that is done needs to be patient centered, from how patients are discharged, to the referrals they subsequently receive, and to the care they are connected to in the community.

CTI is mindful about how to meet both the short- and long-term needs of patients and has developed a system and partners that can support needs on both time frames. The depth and nature of the partnerships have evolved since the launch of the program, and all partners attribute their joint success to ongoing program evaluation and to flexibility and openness to the evolution of those partnerships.

## Contact

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**Everything that is done needs to be patient centered, from how patients are discharged, to the referrals they subsequently receive, and to the care they are connected to in the community.**



# Sinai Health System

## Chicago, Illinois

### *Community Description*

#### Story

Chicago, the third most populous city in the United States, is known for its architecture, food and multicultural metropolitan vibe. The city is vibrant and has a diverse population, yet some communities struggle with high rates of violence, segregation and poverty.

Sinai Health System has been serving communities in the West Side and Southwest Side of Chicago for more than 100 years. The health system is ground zero for efforts to improve population health since it serves residents of some of the most economically challenged areas of the city. These neighborhoods include some of the poorest residents in the city, and community members are disproportionately affected by chronic disease, issues of violence and access to education, jobs and housing.

Sinai Health System is a community health system that must rely heavily on its partnerships to keep its population thriving. Since 2002, community health workers (CHWs) have been central to Sinai Urban Health Institute's work toward eliminating health disparities in Chicago's most vulnerable communities. Sinai works to embody a universal sense of humanity in its approach to serving the community with empathy and understanding. The leaders at the health system are deeply committed to the community as many of them were born and raised in the neighborhoods they serve.

Also, the health system focuses on the city and how all pieces of a complicated puzzle fit together to create possibilities for community members. This approach includes being heavily involved in local and state legislation, maintaining long-standing partnerships with external community organizations and empowering individuals themselves to make their community stronger. Looking at its community as a circle, the health system recognizes that social issues and health issues are connected. No problems are isolated problems, and therefore health care is not limited to the care provided inside a hospital or physician's office.

#### Population

- Community service area is 1.5 million people. (One out of two people in Chicago live there.)
- These are economically challenged communities. Chicago has a 5 percent unemployment rate; the community service area has a 12 percent unemployment rate.
- Diabetes prevalence and the infant mortality rate are double of those in the city of Chicago.
- 25 percent of households have incomes at or below poverty level.
- 90 percent of children live in families with incomes at or below poverty level.
- 51 percent of residents use Medicaid to pay for health care services.

# PRIORITY NEEDS

Mental and behavioral health care



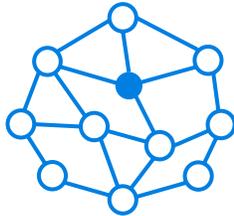
Chronic disease management (particularly, asthma, diabetes and breast health)



Healthy birth and child development



Violence prevention and harm reduction



Housing insecurity



## Community Partnerships

### Sinai Community Institute

For nearly 25 years, Sinai Community Institute (SCI) has provided services that address the social and economic factors that impact the health of the most vulnerable members of Sinai Health System's western Chicago service area. By providing social services in the community, SCI can bridge gaps that, if unaddressed, contribute to poor health. SCI's programs cover the course of people's lives, as the institute sponsors and provides programs for pregnant teens and women, infants and children, parents, youth, young people involved in the juvenile justice system,

the unemployed and the underemployed, seniors and more. These programs, carried out on the health system campus, in clients' homes and at community sites, are designed to empower and educate community members. Through its community outreach and education programs, SCI provides important connections in the community.

### Violence

Violence is a significant issue in the communities Sinai serves. The rhetoric about how dangerous select Chicago neighborhoods are is known across the nation. However, the story that isn't being told is the reduction in violence that has been occurring. The neighborhoods are committed to making their streets safe again and are actively engaged in work to accomplish this. With the help of community members and external organizations, Sinai Health System has been addressing violence from several angles. One way the health system has found success is by engaging youth in the community to actively participate in violence prevention activities, empowering them to promote prevention themselves.

## CeaseFire Chicago

CeaseFire Chicago, part of the Illinois branch of the Cure Violence organization, is supported by the U.S. Department of Justice and the Michael Reese Health Trust. This external organization collaborates closely with Sinai Health System and the surrounding neighborhoods. With case managers in the community and within the hospital, CeaseFire works to de-escalate issues within the community and intervene when patients come to the hospital because of violence-related incidents. Working closely with the hospital staff and law enforcement, this organization focuses on stopping violence before it occurs and intervening before retaliation of violence. The program began in 1995, and its founders spent five years developing a strategy for how to best serve the program's target population. The program was first implemented in West Garfield Park, one of the most violent neighborhoods in Chicago, and it contributed to a 67 percent drop in shootings and killings. The model was then replicated in four more neighborhoods, averaging a 42 percent drop in shootings and killings.

## Gun Violence Research Collaborative

Sinai Health System has assembled a collaborative with the leading academic medical centers in Chicago and with community leaders to research and understand how to address gun violence more effectively. Partners include the United Way, Northwestern University Medical Center, Rush University Medical Center, DePaul University, Ann & Robert H. Lurie Children's Hospital of Chicago and the Illinois Public Health Institute. The group aims to take a transdisciplinary approach with members coming to the group with their respective areas of expertise.

## Behavioral Health

Recognizing that behavioral health is a major issue in the community, the health system has taken a systematic approach to integrating behavioral health care services in the community and primary care. Within the health system, Sinai has a crisis stabilization unit and a new inpatient behavioral health wing. This infrastructure helps build capacity in the community to appropriately care for individuals and keep them out of the criminal justice system. In addition, the health system has several partnerships in the community to address behavioral health outside the hospital.

## Child and Adolescent Behavioral Health – Under the Rainbow Program

Under the Rainbow provides child and adolescent outpatient behavioral health services to more than 2,600 minors each year. Under the Rainbow offers bilingual and culturally sensitive services to children, adolescents and their families to best meet the needs of the communities it serves. Attention deficit hyperactivity disorder (ADHD), depression and bipolar disorders are important concerns, but more than 50 percent of Under the Rainbow clients have attachment disorders as secondary diagnoses.

In addition, more than 85 percent of the youth suffer from post-traumatic stress disorder (PTSD) symptoms due to the complex traumas they experienced during their childhood, increasing the likelihood of further health deterioration during their adulthood. Specialized programs focus on youth who have experienced abuse, neglect and other traumas. Treatment services include individual and group therapies, access to psychiatrists and a 24/7 crisis intervention service that includes mobile



emergency screening, assessment and support for youth in crisis. Under the Rainbow staff also designed a primary school-based program in 2008 to provide children, parents and teachers with services promoting mental and behavioral health.

### **Adult Behavioral Health Program**

Engaging faith-based networks and other community organizations, this program aims to increase access to care and education within the community. Program leaders work with adults with severe mental illness, including schizophrenia, bipolar disorder and severe depression, and help these clients get access to psychiatrists and health services. The program also works to destigmatize mental health in the community by providing education to faith-based networks and empowering community members to educate each other. In 2016, this program had 7,000 instances of services and 131 intakes into the health system. Most of these patients would not have been seen by health care providers otherwise nor received the care they needed.

### **Sinai Urban Health Institute**

Sinai Urban Health Institute (SUHI) was founded in 2000 to serve as a leading urban health research organization for eliminating health disparities and working toward health equity. SUHI's mission is to develop and implement effective approaches that improve the health of urban communities through data-driven research, evaluation and community engagement. Much of SUHI's work involves examining the impact of social issues, such as poverty, on health. Since 2000, SUHI has been awarded more than \$32 million in funding. Members of SUHI have published more than 100 peer-reviewed articles, including original population-based research, secondary data analyses, systematic literature reviews and commentaries. SUHI researchers focus not only on identifying racial and ethnic health disparities but also on understanding the causes of those differences and translating findings into action. Data and information from SUHI inform future and current collaboratives and lead to better ways to serve the community.

### **Health Ministry Program**

Sinai's health ministry program works collaboratively with the faith-based community in Sinai Health System's primary and secondary service areas to identify the health needs of each congregation and link the faith community with resources offered by the health system. The program offers assessments of congregational health needs, on-site health screenings, health-related presentations, health insurance education and enrollment, weight loss support—using the Healthy Body, Healthy Weight, Healthy Soul curriculum to encourage a healthy diet rich in fruits and vegetables—referral assistance to Sinai Health System for identified health issues, assistance in creating a health ministry, and membership in the Clergy Health Ministry Leadership Council



**Much of SUHI's work involves examining the impact of social issues, such as poverty, on health.**



## Impact

Sinai Health System has been going outside the hospital walls to provide a holistic health and wellness model of community care for more than 40 years. The health system provides a comprehensive range of services to improve health outcomes, support strong healthy families, develop the potential of children and youth, build strong community partnerships and enhance economic opportunities. A record of success and achievements has been maintained by viewing the community through a value- and asset-based lens.

- CeaseFire zones have seen a 50 percent decrease in killings since 2004 compared to the 25 percent reduction in the city of Chicago overall.
- Patients who were seen by the CeaseFire case managers were half as likely to have repeated episodes of violence.
- In 2014, the Sinai Urban Health Institute released a report on best practice guidelines for community health worker programs, with lessons learned, case examples and recommendations.
- SUHI members have published more than 100 peer-reviewed articles, including original population-based research, secondary data analyses, systematic literature reviews and commentaries.
- In 2016, Sinai Health System had 80,000 mental health outpatient visits.

## Lessons Learned

Intent to do well is not enough. To make true impact, the organization must be committed to listening to the community and then responding to what it needs.

Cultural competence and sensitivity are essential to gain any trust within a community, especially for marginalized communities that have little faith in the system.

Injecting funds into a community does not solve the problem alone. The organization must engage and train community members to respond and participate. Empower community members to take leadership, take a stand and make a difference.

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# St. Mary's Health System

## Lewiston-Auburn, Maine

### Community Description

#### Story

Lewiston and Auburn, Maine, are twin cities located in Androscoggin County in south-central Maine, along the banks of the Androscoggin River. An urban locale, Lewiston-Auburn is the second largest metro area in the state. Lewiston-Auburn traditionally was an old mill community, but as the mills closed, the twin cities became economically depressed. The area's residents have a strong French-Canadian heritage, and an influx of Eastern and Central African refugees since the early 2000s has further diversified the demographics. Due to this wave of immigrants, there are now more than 25 languages spoken by students at Lewiston High School.

Poverty is a significant issue in Lewiston-Auburn and the county. Androscoggin County's poverty rate is 14.3 percent, and Lewiston's poverty rate is 25 percent, with 67 percent of the population of the downtown area living in extreme poverty. The childhood poverty rate in Lewiston is 42 percent, nearly twice the state average. Not surprisingly, many health indicators for Lewiston-Auburn are worse than the state average.

Lewiston-Auburn is working to revitalize itself. A committed team from St. Mary's Regional Medical Center, St. Mary's Nutrition Center, Central Maine Medical Center, Healthy Androscoggin and numerous community-based organizations is dedicated to helping Lewiston-Auburn flourish by collaboratively addressing the determinants of health in the community.

#### Population

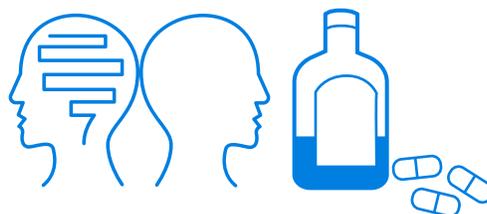
- There are approximately 60,000 individuals living in Lewiston-Auburn and 107,000 in Androscoggin County.
- Nearly 92 percent of county residents are white. Due to the migration of African immigrants and refugees, 8 percent of Lewiston's residents are black.

## PRIORITY NEEDS

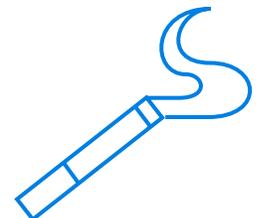
Chronic disease – diabetes, cardiovascular disease, respiratory disease



Mental health and substance use disorders, including opioids



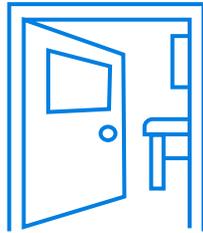
Tobacco use



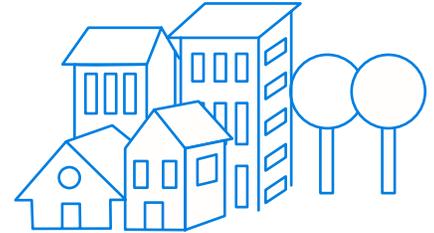
Obesity



Access to care



Social determinants of health



[poverty, poor housing stock, (lead) poisoning, food insecurity, lack of transportation]

# Community Partnerships

Robust community partnerships are core to the work of improving health in Lewiston-Auburn. There is communitywide recognition that it takes more than health care to build a Culture of Health—that everyone needs to work together to support the community. The community has been intentional about developing deep, long-standing relationships among different stakeholders including clinical providers, city government, social service organizations, academic institutions, coalitions, police, schools and small businesses to transform systems where there is burden and poor health outcomes.

The hospital uses a health equity framework that addresses the determinants of health to influence environmental change, particularly to address the needs of the immigrant communities and residents living in poverty.

Key partners in Lewiston-Auburn’s Culture of Health work are:

## St. Mary’s Regional Medical Center

The medical center is a member of Covenant Health and part of St. Mary’s Health System. The mission

of St. Mary’s Regional Medical Center is to provide healing and serve the most vulnerable individuals in the community. The hospital has taken that mission in stride, making investments in staff and in the physical environment in Lewiston. A hospital leader commented on a desire to “dissolve hospital walls,” a perspective that is indicative of the hospital’s role as an anchor in the community.

## Central Maine Medical Center

CMMC is located less than a mile away from St. Mary’s, and the two hospitals work collaboratively to improve health for their shared community. CMMC has functioned as a community hospital since its founding 120 years ago. The hospital is a key partner in numerous community health organizations, including Let’s Go 5-2-1-0, Safe Voices, Tri-County Mental Health Services, United Ambulance Services, Trinity Jubilee Center, and Tree Street Youth Center.

## Healthy Androscoggin

A community coalition, Healthy Androscoggin empowers people to live healthy lifestyles and improves the public health of the communities it serves through planning, community action, education and advocacy. Healthy Androscoggin helps identify needs, find partners and make changes through its focus on tobacco, substance use disorders, physical activity, healthy eating and lead poisoning. Successes that Healthy Androscoggin has realized in the community include: lowering the childhood lead poisoning rate in Lewiston-Auburn from 9.3 percent to 6.7 percent in five years; significantly reducing alcohol use rates among youth; changing youth perceptions about how easy it is to obtain alcohol; decreasing tobacco use rates among youth; and increasing healthy eating and cooking skills.

## Improving Access to Healthy Foods

### St. Mary's Nutrition Center

The Nutrition Center at St. Mary's Regional Medical Center developed out of a 1999 initiative called Lots to Gardens, which transformed abandoned lots around Lewiston into community gardens. Established in 2006, the Nutrition Center (NC) promotes community health through organizing, advocacy, and education with a special focus on supporting people with limited income who are at risk of becoming food insecure. The Nutrition Center is located in a historic school house in downtown Lewiston, in the city's most diverse and economically challenged neighborhood, where stores often do not carry high-quality produce. Serving as a true community center, the Nutrition Center has a downtown location that is accessible to the community it serves. Hospital leaders note that food can function as a building block of communities by fostering a fabric of connectedness.

In addition to providing food to residents, the Nutrition Center intentionally uses food as a tool for community building, leadership and youth development, and neighborhood revitalization, doing this through numerous strategies:

- Community gardens. Through Lots to Gardens, empty lots around Lewiston have been transformed into community gardens to grow fruit and vegetables. The community gardens provide not only food but also a unique opportunity for community members to become engaged in producing their own food. The gardens also build a sense of community, pride in neighborhoods and friendship among neighbors.

- Food access and emergency food. Believing that everyone should have access to fresh, nutritious food that is culturally appropriate, the Nutrition Center provides access to high-quality food through its food pantry, farmers markets and incentive programs. The Nutrition Center's Good Food Bus takes fresh produce to neighborhoods that do not have access to fresh food. The food supplied is from Maine farms to support the local economy and build a stronger food system.
- Nutrition education. The Nutrition Center has a teaching kitchen and offers hands-on cooking classes for Lewiston residents of all ages. Participants learn healthy cooking and eating techniques. Community cooking programs extend to the elementary and high schools, as part of integrated nutrition and school garden programming.
- Youth engagement and empowerment. The Nutrition Center supports youth leadership programs to help young people develop their voices while learning skills in urban and school gardens, kitchens and social justice workshops. After "graduating," participants can go on to become interns and leaders who serve as youth advocates in their schools or to hone their culinary skills.
- The Nutrition Center has evolved into a community center. By weaving together direct support with education and community change strategies, the NC builds resiliency at the individual, family and community levels.



Photos courtesy of St. Mary's Regional Medical Center

## Collaborative Community Health Needs Assessments

### Maine Shared Health Needs Assessment and Planning Process – SHNAPP

A largely rural state, Maine conducts a statewide community health needs assessment. The Maine Shared Health Needs Assessment and Planning Process (SHNAPP) is a collaborative effort among Maine's four largest health care systems – Central Maine Healthcare, Eastern Maine Healthcare Systems, MaineGeneral Health, and MaineHealth – as well as the Maine Center for Disease Control and Prevention. The goal of SHNAPP is to “turn data into action” by conducting a shared community health improvement planning process for stakeholders across the state. SHNAPP functions in three phases:

1. Assessment: reviewing community health status through epidemiological reviews and surveys
2. Community engagement: involving the community in order to identify priorities, guided by initial quantitative findings; encompassing the scope of community voices; providing outreach to go to “other people's parties”
3. Health improvement plan: collaborative planning of strategies to address health needs

## Community Safety and Violence Prevention

### United Ambulance Service Community Paramedic Program

In the Community Paramedic Program, the paramedic takes on a preventive and educational role, working with high-risk, frequent users of the health care system. The paramedic visits patients in their homes to provide basic medical intervention, improve patients' awareness of how to manage their own health, and evaluate the living spaces for hazards. The program addresses the primary care requirements of high-need patients and helps identify and address the social needs of individuals. Services offered include home inspection and safety checks, medication review, well-being checks, chronic disease education, wound care, and influenza vaccinations

### Auburn PAL (Police Activities League) Center

The Auburn PAL Center provides educational and athletic activities for kids after school and during the summer, and also fosters positive interactions with police officers. The Auburn police department is working to prevent violence and decrease school suspensions in order to keep at-risk youth out of trouble. The city of Auburn turned over vacant property to the police department to open this center in the heart of the city.

## Healthy Homes and Environment

### Lewiston-Auburn Green & Healthy Homes Initiative

Lewiston-Auburn's housing stock is aging, causing numerous safety hazards, most notably lead poisoning, asthma, fall hazards and unsafe radon levels. Lewiston-Auburn has the highest rates of childhood lead poisoning in Maine due to the city's old housing stock. Much of the dangerous housing is located in the downtown area of Lewiston, where the most economically disadvantaged families live. One Somali resident noted, “We don't think about lead. This is perfect compared to what we had.” To respond and alleviate these conditions, a coalition of partners from health care, public health, education, tenants' rights and other community-based organizations are partnering to coordinate interventions and provide education to address home-based health and safety hazards. With the help of a Housing and Urban Development grant, the partners are braiding resources to support healthy homes.

## Accessible and Culturally Appropriate Health Care

### B Street Health Center

B Street clinic is a federally qualified health center located in downtown Lewiston and an anchor for investment. B Street is accessible to the high-need populations in the downtown area. Providers at the clinic see a high proportion of Somali immigrants and have been leaders in providing culturally competent care. The clinic, which has become a trusted location for care, has improved access to care and also provides opportunities for immigrants to be trained as cultural brokers and medical interpreters, benefiting patients and the community. The clinic is also linked with mental health providers, transportation services and legal services to support the clinic's patients.

## Impact

### St. Mary's Nutrition Center

- The urban community gardens support 140 low-income households to grow their own food.
- The school garden and children's cooking programs have reached more than 900 students in 40 classrooms.
- The Nutrition Center provides cooking skills and nutrition education programs for more than 800 adults and seniors and an intensive leadership development and job training program for more than 50 teens annually.
- The food pantry handles emergency food distribution so that more than 2,500 people enjoy fresh produce and groceries from the pantry each month.

### Green & Healthy Homes

- The Green & Healthy Homes program supports comprehensive intervention in 28 homes.
- In 2016, the group prioritized and completed policy development, unit production, fundraising and data for priority areas.
- The group is partnering with the Lewiston Area Public Health Committee to explore lead renovation, repair and painting policy (making it a requirement for builders to provide proof of RRP certification at time of building permit application when working on a pre-1978 building) in conjunction with code enforcement.

### Community Paramedic Program

- The program has resulted in reduced 911 calls, decreased nonemergency ED visits, and reduced hospital readmissions.
- In 2016, United Ambulance made 1,954 community paramedicine interventions in the community.

## Lessons Learned

Respectful, collaborative relationships and authentic community engagement are key to community health initiatives in Lewiston-Auburn. The passionate, devoted staff have the hospital administration's support and also the trust and respect of diverse community groups and community stakeholders. Placing the Nutrition Center in downtown Lewiston demonstrates St. Mary's commitment to meeting people where they are and truly being part of the community. The work being done in Lewiston-Auburn should be a model for small, rural hospitals everywhere: If you are dedicated to your community and work collaboratively, transformational change is possible.

## Contact

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# St. Vincent Healthcare

## Billings, Montana

### Community Description

#### Story

Yellowstone County, located in the frontier of Montana, is the most populous county in the state. The county is named for the Yellowstone River that bisects it to create the southwest and northeast regions of the state. Founded as a railroad town in 1882, Billings is Montana's largest city. Known for its beautiful landscape, this region is so geographically spread out that locals consider anything within a four-hour drive as "close by." The community is a mix of part small metropolitan region and part frontier area. Frontier areas are sparsely populated rural areas that are isolated from population centers and services. The region also includes two Native American reservations.

The region has two main health care systems, St. Vincent Healthcare and Billings Clinic, which share the market equally. Competitive in some ways and collaborative in other ways, the two health systems have fostered a partnership to deliver community services and lead initiatives outside the hospitals.

#### Population

Yellowstone County covers an area of 2,635 square miles with a total population of 155,634, and it is considered 17 percent rural. The county's population is 91.5 percent Caucasian. The median household income is \$45,456, and 12 percent of people in the county live in poverty. Nearly 10 percent of all families and 33 percent of single-parent families with a female head of household have incomes below the poverty level.

## PRIORITY NEEDS

Healthy weight status



Access to health services



Mental and behavioral health



# Community Partnerships

## Healthy By Design

The Healthy By Design Coalition was formed by the Alliance, an affiliated partnership of the two hospitals, St. Vincent Healthcare and Billings Clinic, and also RiverStone Health which is the City-County Health Department. The Healthy By Design coalition has been a collaboration with diverse cross-sector partners from community-based organizations, government organizations, faith-based organizations and health care organizations. The coalition work focuses on policy, system and environmental change strategies to address identified community health needs. For example, the coalition successfully advocated for a Complete Streets Policy for the city of Billings to increase access to opportunities for safely engaging in physical activity. Operationally, each of the three organizations provides about one third of the resources and has clearly outlined roles, responsibilities, financial commitment and goals. This arrangement is confirmed through a signed memorandum of understanding.



Photo courtesy of St. Vincent Healthcare

## Community Crisis Center

The Community Crisis Center was created by a partnership of Billings Clinic, St. Vincent Healthcare, RiverStone Health and South Central Montana Regional Mental Health Center. The center has been sustained with financial contributions from the hospitals, support from a public safety mill levy, and other grants. The Billings Community Crisis Center is the only facility in Montana licensed as an outpatient crisis response facility. These facilities provide evaluation, intervention and referral services to individuals who are experiencing a crisis because of a serious mental illness or a serious mental illness with a co-occurring substance abuse disorder. This type of facility offers services targeted at individuals who might otherwise be taken to jail or treated in a hospital emergency room.

Individuals who come through the Community Crisis Center are given a three- to five-year plan for recovery and provided with assistance and resources to prevent them from being arrested or going to the emergency room. The local federally qualified health center also works collaboratively with the crisis center and provides same-day appointments. The crisis center is staffed by licensed mental health professionals 24 hours a day, but individuals are not admitted to the facility for an overnight stay. It has a “no wrong door” policy and takes walk-ins and anyone referred by the hospital, law enforcement, family and friends

## Walla Walla University of Billings Campus Mental Health Clinic

This graduate training facility is dedicated to providing mental health services to the Yellowstone County community. The clinic is staffed by student clinicians who work collaboratively under the supervision of

licensed clinical social workers to provide therapy for individuals, couples and families. Services are provided regardless of an individual's ability to pay. St. Vincent Healthcare partners with this program, providing support and further resources to clients if needed. The program began initially with funding through the Mobilization for Health: National Prevention Partnership Awards program of the HHS Office of the Assistant Secretary for Health. This award is referred to locally as the Healthy By Design DE-STRESS Grant. More than 50 percent of the students who staff this program are from the local area, and they hope to complete their training and continue to serve the local community.

### Diabetes Prevention Program – YMCA Partnership

The state of Montana has given St. Vincent Healthcare a grant for diabetes prevention, which the hospital has been implementing in partnership with the local YMCA. Following the Centers for Disease Control curriculum, this referral-based, 12-month program begins with an intense intervention focused on lifestyle behaviors and health management. Program participants also have access to YMCA exercise classes and facilities with no upfront membership fee. These services provided through the YMCA are partially funded through the state grant and hospital donations.

### Foster Grandparent Program – Corporation for National and Community Service

Sponsored by St. Vincent Healthcare for over 45 years, this program is part of Senior Corps, a national program committed to providing senior citizens in the community an opportunity to be active and social. Program participants, age 55 or older, volunteer regularly based on their skills



**Foster grandparents can mentor young teens or young mothers or help care for premature infants, children with disabilities or children who have been abused or neglected.**



and ability. Opportunities for foster grandparents include volunteering at local elementary schools to help children learn to read and provide one-on-one tutoring. In addition, foster grandparents can mentor young teens or young mothers or help care for premature infants, children with disabilities or children who have been abused or neglected. Senior Corps believes that foster grandparents are “role models, mentors and friends to children,” and this program provides a way for senior citizens to “stay active by serving the children and youth in their communities.”

## Impact

- The 2017 community health needs assessment showed positive impact of the work of the Healthy By Design coalition for physical activity rates. The percentage of residents reporting no leisure time physical activity decreased significantly from 23.7 percent in 2014 to 18.0 percent in 2017, meeting Healthy People 2020 targets.
- In 2015, 104 participants enrolled in the Diabetes Prevention Program, including 49 Medicaid beneficiaries and 78 with a walking disability. Nearly half of participants achieved a 5 percent weight loss after 10 months, with a mean weight loss of 10.3 pounds at four- and 10-month evaluation time frames.
- In 2016, 56 Foster Grandparent volunteers served 42,468 hours, helping 570 children who had been identified by teachers as needing mentor/tutor assistance. Of the 570 children served: 41 had an incarcerated parent; 18 were in foster care; 7 had an active military family member; 24 were from a family of a veteran; and 35 were homeless.

## Lessons Learned

Definition of population health can differ among organizations. It is important to find a common language when starting initiatives.

In more rural areas, collaboration is key because limited resources are available to address the needs of a large geographic and sparsely populated area.

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# University of Vermont Medical Center

## Burlington, Vermont

### Community Description

#### Story

Burlington, Vermont, is known for its scenic landscape and being the first city in the United States to source 100 percent of its energy from renewable sources. This environmentally conscious city, the most populous in the state, is home to the University of Vermont and the state's largest health system and only academic medical center, the University of Vermont Medical Center (UVM Medical Center). Even with a county population of more than 160,000 people, the community is tight knit and values the preservation of its history and culture.

Vermont is in the process of implementing an all-payer accountable care organization (ACO) model with the Centers for Medicare & Medicaid Services, the most significant payer throughout the state. This model, which incentivizes health care value and quality with a focus on health outcomes, has transformed the relationship between care delivery and public health systems across the state. Moving toward single-sourced contracting and capitated payment, UVM Medical Center is committed to health and wellness of its surrounding community and collaborates with local, state and federal organizations to create programing and provide resources and investments in the community.

#### Population

According to its 2016 community health needs assessment, Burlington is the most ethnically and racially diverse city in the state with roughly 8 percent of its residents from a racial or ethnic minority group compared to 5 percent for the state of Vermont. The uninsured rate in Burlington in 2016 was 2.5 percent.

Homelessness is a prominent issue in this region. This determinant of health affects chronic disease management, substance use disorder and mental health. The city and neighboring communities work closely with the health system and local organizations, including the chamber of commerce and regional economic development organization to find creative ways to address this issue.

## PRIORITY NEEDS

Access to healthy food | Affordable housing | Chronic conditions



# Community Partnerships

## Community Health Investment Committee

Led by the hospital, the Community Health Investment Committee focuses on how to fund and invest in programs and initiatives in Burlington. Going beyond the traditional community health improvement plan (CHIP) and community health needs assessment (CHNA) process, this committee meets every month and invests about 2.5 percent of the hospital's net revenue in community-based work that addresses needs identified in the most recent CHNA. Members of the committee include the chief financial officer of UVM Medical Center, the director of population health, members from the strategic planning team, a social worker that works closely in the community, local police, health planning representatives, a designated United Way member and other community representatives. The committee includes six community representatives and six medical center staff.

### **Chittenden County Homeless Alliance**

With the mission to end homelessness in Vermont, a large alliance formed that includes the Vermont Agency of Human Services, Department for Children and Families, Champlain Housing Trust, city of Burlington, Veterans Affairs office, Vermont Legal Aid, and Burlington Housing Authority. The group works together by sharing information, developing resources, providing a forum for decision-making and promoting decent, safe, fair and affordable shelter.

### **Champlain Housing Trust**

This trust covers three counties in the northwest region of Vermont and is a part of the Chittenden Homeless Alliance. With a budget of more than \$10 million, the Champlain Housing Trust provides affordable housing for more than 6,000 people. The trust has purchased and renovated motels and converted them into free and subsidized housing,

currently housing 19 people with this model. The hospital works closely with this trust on numerous projects and has prepaid for a certain number of these units to house patients that might need the service. At these sites, residents also have access to a personal caseworker from a community program called Safe Harbor, the homeless health clinic run by the area's only federally qualified health center, the Community Health Centers of Burlington. The case workers provide legal assistance and help residents address housing, family and domestic violence issues. This program is funded through a combination of state, grant and hospital funds. Repurposing vacant or run-down motels for this purpose has created an extraordinary resource in the community as homelessness continues to increase in the region.

## Service Coordination Program — Street Outreach

Established in 2000 to address concerns of downtown Burlington merchants, the Burlington Police Department and area service providers, the Street Outreach team works with individuals in the downtown Burlington business district. This small but mighty team knows community members well and takes shifts spending time on the city's downtown streets, helping any individuals in need. The team assists those with mental health, substance abuse, homelessness, and unmet social service needs and coordinates services for those individuals. Team members also work closely with service providers, police and merchants to keep the downtown area safe without using unnecessary police action. This outreach provides a safety net for people to get help when they need it and also keeps this high-traffic, tourist-friendly region a comfortable and safe environment for everyone.

### **Chittenden County Opioid Alliance**

This alliance is between key state and local government leaders, community members and leaders from nonprofit organizations, including the health system. The aim is to reduce opioid abuse in the community using action teams to address treatment and recovery, prevention, workforce and rapid intervention. Using a collective impact framework as a model, this alliance focuses on data-driven work and relies on shared outcomes, mutual accountability, continuous communication and strong backbone support provided by staff specifically dedicated to this effort

### **Community Engagement – ECOS (Environment, Community, Opportunity, Sustainability)**

In 2012, the Chittenden County Regional Planning Commission received a \$1 million Sustainable Communities grant for urban development from several federal agencies, with the U.S. Department of Housing and Urban Development being the lead funder. The Regional Planning Commission engaged 19 municipalities and more than 40 nonprofit organizations to create the ECOS Plan for regional sustainability, which includes a land use plan, regional transportation plan, Comprehensive Economic Development Strategy (CEDS) and, for the first time, a large section on the social community. A steering committee that includes the hospital, chamber of commerce, United Way and other organizations oversees the effort, ensuring the plan will continue to focus on understanding community needs and to create and make available resources around the social determinants of health for the population. Currently, the two principal foci are the Opioid Alliance (described earlier) and Building Homes Together, a 60-plus organization collaboration committed to building 3,500 homes in the county by 2021.

## *Impact*

- In a year's time, from second quarter 2016 through May 2017 (based on preliminary 2017 data), the average number of individuals each quarter waiting for treatment at the Chittenden County hub decreased from 289 individuals to 103 individuals, a decrease of 64.4 percent. Between January and June 2017, the average number of days each month an individual waited for treatment at the Chittenden County hub decreased from 80 days to 58 days, a decrease of 27.5 percent. All of this resulted in increased access to care in the community.
- With the ECOS collaborative working together, the community reduced homelessness from 471 individuals in 2015 to 332 individuals in 2016, a 30 percent reduction.
- Since Harbor Place, one of the renovated motels, opened in 2013, the medical center has paid for a total of 1,720 nights for 153 patients through 2016 (approximately \$51,600).

## *Lessons Learned*

The work is about relationships; collective impact is built "at the speed of trust."

Inclusion is essential: Think about who is not at the table and make sure to bring them in.

The convener should be credible and neutral.

The health system does not need to be the sole or major funder for all community initiatives. Get creative and try to involve local, state and federal agencies.

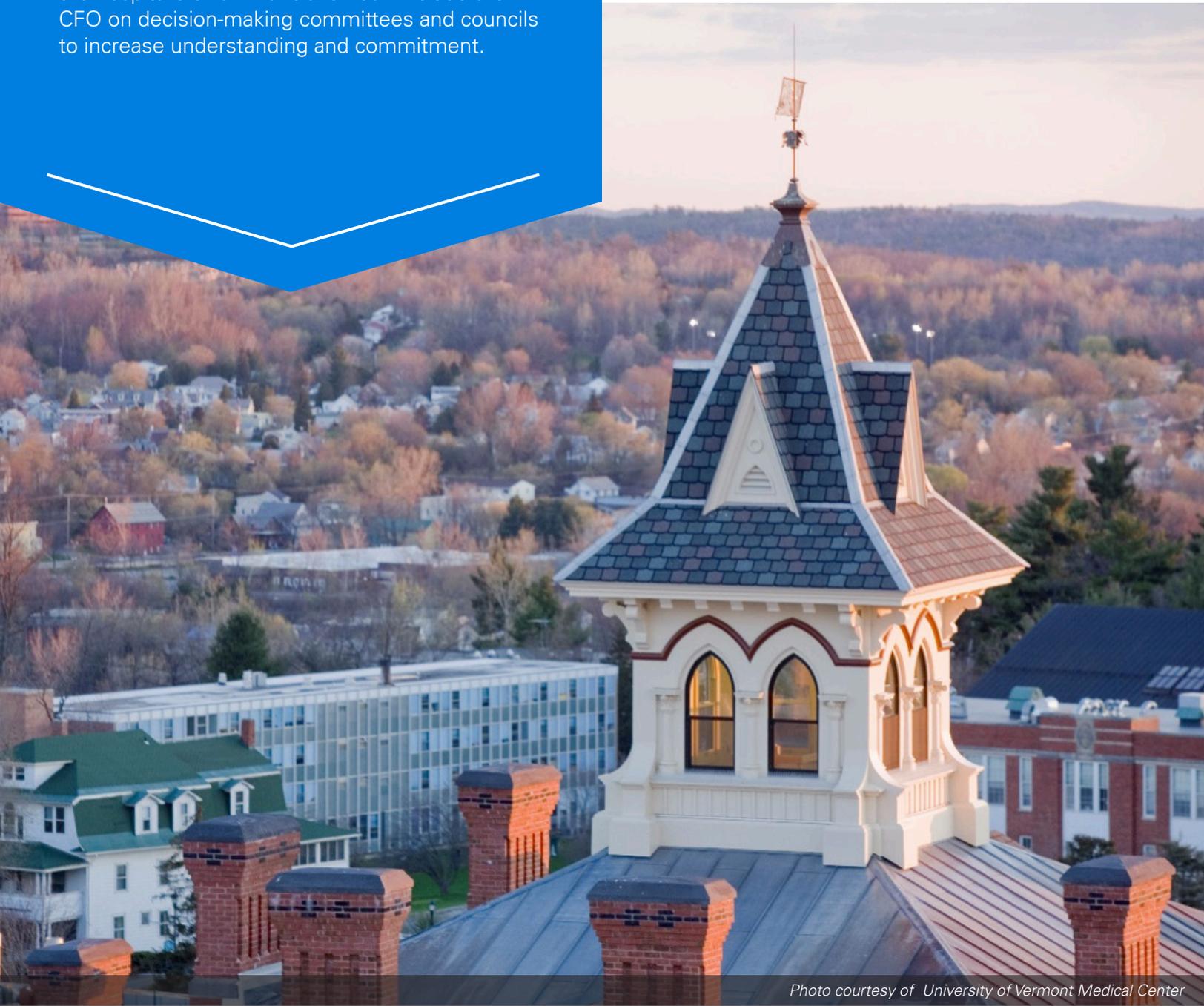
Executive leadership support and involvement make a difference, including commitment from the hospital's chief financial officer. Include the CFO on decision-making committees and councils to increase understanding and commitment.

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# WNC Health Network

## Western North Carolina

### Community Description

#### Story

Western North Carolina is a primarily rural, mountainous Appalachian region with a population of fewer than 800,000 people across 16 counties. The communities vary in size, with Buncombe County (population 250,539) as the mostly densely populated. The culture and natural beauty of this area attract visitors from around the world, while many families have called it home for generations. This mix of deep tradition and innovative economy creates a rich regional patchwork of unique communities.

Though the mostly rural context of western North Carolina creates challenges, the culture and closeness of community members have created a thriving environment for collaboration and innovation, both locally and regionally.

#### Population

Compared to the entire state of North Carolina, western North Carolina:

- Is about 7 years “older” (median age of population is 45 years)
- Has lower proportions of all racial and ethnic groups (89 percent white), except American Indians/Native Americans, as the region is home to the Eastern Band of Cherokee Indians
- Makes \$7,649 less income per household (\$39,219 average household income)
- Has a larger number of adults with only a high school diploma (15 percent higher average)

## PRIORITY NEEDS

Chronic disease prevention and management



Mental health and substance abuse



Social determinants of health



# Community Partnerships

## WNC Healthy Impact

WNC Healthy Impact is a partnership among hospitals, public health agencies and key regional partners in western North Carolina that aims to improve community health by building capacity for collective impact. As these entities take part in the community health improvement process, they are working together locally and regionally to assess health needs, develop collaborative plans, take coordinated action and evaluate progress and impact. This innovative regional partnership is supported by financial and in-kind contributions from hospitals, public health agencies and partners. WNC Healthy Impact is housed and coordinated by WNC Health Network.

WNC Healthy Impact goals:

- Enhance partnerships between hospitals and public health agencies
- Improve efficiency, quality and standardization of community health assessment data collection and reporting of data and plans
- Encourage strategic investment of community resources to address priority health issues
- Catalyze and coordinate action among existing and new assets and initiatives to address priority health needs
- Monitor results to improve process, quality, and health outcomes
- Promote accountability of hospitals and public health agencies by meeting state and national community health improvement requirements

Community health improvement (health assessment, planning, action and evaluation) is still a locally led and implemented process. This regional initiative

is designed to support and enhance local efforts by standardizing and conducting data collection, creating reporting and communication templates and tools, encouraging collaboration, providing training and technical assistance, building capacity to address regional priorities and sharing evidence-based practices. WNC Healthy Impact formed in late 2011, with partners coming together in a regionwide community health needs assessment data collection effort in 2012, and again in 2015. The next community health assessment data collection will take place in 2018.

These more recent initiatives are supported by WNC Healthy Impact and available to all public health agencies and hospitals in the western North Carolina region.

### Spread of Results-Based Accountability™

- Results-Based Accountability is a disciplined, common-sense approach to thinking and taking action with a focus on how people, agencies and communities are better off for such efforts.
- Through WNC Healthy Impact, all WNC hospitals and public health agencies, as well as their local partners, have access to training, coaching and technical assistance in Results-Based Accountability™ for community health improvement. Of those trained, almost all agree that the use of Results-Based Accountability is an improvement over their usual way of monitoring and improving performance.

### Electronic Community Health Improvement Plans

- A community health improvement plan (CHIP) serves as a strategic health improvement plan that is designed to communicate what is taking

place across the community related to priority health needs.

- WNC Healthy Impact provides cloud-based electronic templates and related technical assistance for community and tribal health improvement plans in western North Carolina. This approach offers accessible data-tracking and display tools that can be customized to each community's needs. The electronic template helps organize community health improvement efforts and make it easier to connect and share across agencies. Many partner hospitals are also using an electronic hospital implementation strategy scorecard template co-developed as part of WNC Healthy Impact.

## Local-level Community Partners

While the support of WNC Healthy Impact bolsters communities in the western North Carolina region, public health agencies and hospitals still help drive health improvement in their own communities.

### **McDowell County Health Coalition**

This single, county-based coalition is organized to enhance and promote community health. Members of the coalition include diverse stakeholders across the community. The coalition has had great success in building partnerships that result in innovative health improvement strategies focused on enhancing the quality of life and well-being of all residents. Its members are committed to addressing health disparities and strengthening grassroots leadership to lead that effort. In that vein, the coalition is dedicated to partnering with traditionally marginalized communities and resourcefully meeting the entire community's social determinants of health.

The coalition's goals include:

- Cultivate leadership and provide a vehicle for community stakeholders to drive progress and social change across McDowell.
- Address health disparities and strengthen grassroots leadership to lead that effort.

- Promote good communication and open discussion on health issues.
- Increase access to healthy local food, especially for food-insecure residents.
- Increase access to health care, preventive services and affordable health insurance.
- Provide wellness options and healthy choices for people where they live, work, play and pray.
- Address the community's social determinants of health, which includes the environment and infrastructure (access to public transportation, affordable housing and child care).

The coalition is an example of how a county can come together to pool resources and find a common goal to improve community health. It organizes initiatives by pods, which are groups of leaders who work together on a focused community transformation effort. These efforts equal a communitywide initiative that will result in a healthier, stronger McDowell for generations to come.

### **McDowell Access to Care and Health (MATCH)**

This network connects uninsured community members to health care and support services. It is designed to improve access to care and engage participants in their physical, behavioral and social health by connecting them to services throughout the community. The program significantly improved client health outcomes (A1c levels, lowered ED utilization) in its first year. The network is funded by the Kate B. Reynolds Charitable Trust and more than \$200,000 local, in-kind contributions.

### **WorkFORCE Wellness Program**

This program is a comprehensive workplace wellness model that provides free evidence-based resources and health coaching to employers across the county, including the Centers for Disease Control and Prevention's Worksite Health ScoreCard. This grant-funded initiative helps local employers make their respective worksites a healthier place and connects their employees to free or low-cost local resources. This program is funded by the Kate B. Reynolds Charitable Trust and the Community Foundation of Western North Carolina.

## Impact

Results from collaboration through WNC Healthy Impact include:

- 100 percent of public health agencies and hospitals in western North Carolina have collaborated through WNC Healthy Impact since its beginning in 2011.
- 82 percent of public health agencies in western North Carolina now use an electronic scorecard-based community health improvement plan, and 63 percent of hospitals use an electronic hospital implementation strategy.
- 100 percent of public health agencies and 81 percent of hospitals have received technical assistance and coaching in Results-Based Accountability and using scorecard templates in the past two years.
- 93 percent of WNC Healthy Impact participants rate the value that this collaborative provides to the region as “high,” based on a 2017 survey.

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## Lessons Learned

Community health improvement is complex and sometimes can feel overwhelming. Success in this space requires appreciating the complexity and continuing to find a path forward within it.

It's not enough to have a good idea. Meaningful change requires strategy, continuous nurturing and improvement.

Successful collaboration builds trust and a foundation for future collaborative success.

Codevelopment of processes and products is worth the front-end time investment.

This strategy requires a very intentional connectivity between regional and local efforts. This was critical in the early phase of development and continues to be a key to success. The continuous communication across a project of this scale and depth requires constant attention.



# Appendix

The following photos are from two *Learning in Collaborative Communities* convenings in 2016 and 2017.





# Resources

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**Here are additional resources from the American Hospital Association and the Robert Wood Johnson Foundation on building a Culture of Health, creating effective partnerships and improving population health.**

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