Public Health and Hospitals: Lessons Learned From Partnerships in a Changing Health Care Environment

Recent changes in policymaking, such as the passage of the Patient Protection and Affordable Care Act, have ushered in a new era in community health partnerships.

To investigate characteristics of effective collaboration between hospitals, their parent systems, and the public health community, with the support of major hospital, medical, and public health associations, we compiled a list of 157 successful partnerships. This set was subsequently narrowed to 12 successful and diverse partnerships. After conducting site visits in each of the partnerships' communities and interviews with key partnership participants, we extracted lessons about their success.

The lessons we have learned from our investigation have the potential to assist others as they develop partnerships. (*Am J Public Health*. 2016;106:45–48. doi:10.2105/AJPH.2015.302938)

F. Douglas Scutchfield, MD, Lawrence Prybil, PhD, Ann V. Kelly, MHA, and Glen P. Mays, PhD, MPH

This most recent study of public health and hospital partnerships had its genesis in spring 2012 at the Keeneland Conference in Lexington, Kentucky, when the president of the American Hospital Association made an observation that seemed, at the time, astonishing:

> We are all in this together, yes, both the medical system and the public health system, and we are needed if we are to generate that epidemic of health or if we are ever to achieve truly accountable health communities. . . . We need to know the most effective collaborative models to pursue. . . . As we work together toward an integration of public health and patient care into ongoing sustained population health, what policy and implementation potholes do we need to avoid?[1]

The reactors to that charge were the executive directors of the Association of State and Territorial Health Officials and the National Association of County and City Health Officials, who collaborated with the hospital community in a common concern for community health. All three embraced the opportunity to work in common pursuit of an "epidemic of health."

But the question that was raised regarding the most effective collaborative models was an issue that remained after the conference. At the time, there was little readily available information about effective collaboration between hospitals, their parent systems, and the health community. Although these partnerships have existed in the past, recent anecdotal reports of successful collaborative partnerships focused on improving community health prompted us to undertake this study. In it, we compiled a list of successful partnerships involving hospitals and public health agencies, distilled the lessons learned from their experiences, and developed eight core characteristics and 11 evidence-based recommendations to guide others' efforts to build successful community partnerships. They are described in the resulting report.[2]

First, we identified characteristics of successful partnerships, including in health and other sectors, from the literature. We then went through a series of steps to identify collaborative partnerships that (1) existed for at least two years, (2) included hospitals and public health departments, and (3) focused on improving community health. With the support of major hospital, medical, and public health associations and with some exploration on our own, we identified partnerships that exhibited the success characteristics and existed before passage of the Affordable Care Act (ACA; Pub L No. 111–148). We collected 157 nominations for study participation electronically. In early 2014, we reviewed these and narrowed them down through a series of assessment steps, resulting in a set of 12 highly successful and diverse community partnerships (Box 1).

In two-day intensive site visits to 12 partnerships, conducted between April and June 2014, we examined the partnerships' genesis; membership and organization; mission, goals, and objectives; funding support; and metrics for performance monitoring. We tabulated and analyzed the information we collected through the site visits and partnership document review, and we prepared a detailed report.[2]

Because the nominated partnerships were established before implementation of the ACA, these pioneers may be harbingers of a changing paradigm for improving the health of populations. On the basis of the lessons learned from the collective experience of these successful partnerships, we have shared our observations to guide others pursuing similar initiatives,

ABOUT THE AUTHORS

All authors are with the College of Public Health, University of Kentucky, Lexington.

Correspondence should be sent to F. Douglas Scutchfield, MD, University of Kentucky, 121 Washington Ave, Rm 212, Lexington, KY 40526 (e-mail: scutch@uky.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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PARTNERSHIPS INCLUDED IN THE STUDY POPULATION: 2014

Partnership Name	Location
National Community Health Initiatives Kaiser Foundation Hospitals and Health Plan	Oakland, CA
California Healthier Living Coalition	Sacramento, CA
St. Johns County Health Leadership Council	St. Augustine, FL
Quad City Health Initiative	Quad Cities, IA–IL
Fit NOLA Partnership	New Orleans, LA
HOMEtowns Partnership MaineHealth	Portland, ME
Healthy Montgomery	Rockville, MD
Detroit Regional Infant Mortality Reduction Task Force	Detroit, MI
Hearts Beat Back: The Heart of New Ulm Project	New Ulm, MN
Healthy Monadnock 2020	Keene, NH
Healthy Cabarrus	Kannapolis, NC
Transforming the Health of South Seattle and South King County	Seattle, WA

recognizing the inherent limitations in studying a limited number of successful partnerships.

BUILDING SUCCESSFUL PARTNERSHIPS FOR COMMUNITY HEALTH

An emerging focus on and commitment to population health by many components of the health care system, particularly hospitals and health systems, is manifest through increasing collaboration with the public health system and collective action, rather than independent, uncoordinated "random acts of kindness by hospitals." The shifting focus of the health care system, encouraged in part by ACA provisions, recognizes the concerns of prevention and the socioecologic determinants of health. This is illustrated by the rapid increase in the number of publications from hospital organizations on population health[3,4] and the 157 nominations submitted for consideration in our study.

As communities across the country recognize the need to engage multiple stakeholders in addressing community health issues, there is a sense of anticipation about the potential impact of collaborative efforts. However, establishing and maintaining any type of partnership model is inherently difficult. The evidence in many sectors shows that success depends on the extent to which partnerships incorporate certain characteristics, including a vision, a mission, and goals that key constituencies understand and strongly support; a high level of trust among the partners; highly qualified and dedicated leadership; solid metrics for measuring performance; and a strong commitment to continuous evaluation and improvement.[2]

From our observations, even with the dedicated commitment and energy of all collaborative partners, bending the curve of health status in a community is hard work. Frequently, community health initiatives require considerable time to achieve improvements that depend on (1) the time required to implement the intervention and see the results, and (2) the appropriate use of evidence-based interventions. To sustain the partners' interest over extended periods, partnership leaders advise celebrating short-term successes while continuing to focus on longer-term health status improvement goals.

MULTISECTOR DIVERSE PARTNERS' CONTRIBUTION

The coalitions we studied were broad in their membership, with partners drawn from many sectors. With leadership by a public health department or a hospital (or its health system) or both, all involved other community-based service providers, city and county governmental units, school systems, and other educational institutions. For example, the successful Quad City Health Initiative—a unique partnership that involves hospitals, local health departments, social service agencies, educators, and businesses among other partners from Iowa and Illinois—was seen as a model by that community for collaboration in economic development.

We found that the Kaiser Foundation Hospitals and Health Plan was the only partnership in which a health plan had a leadership role. Health plans stand to benefit from cost savings that would result from improved community health, so their absence was noticeable. Although many major businesses supported their staff involvement in partnerships, the businesses themselves were not principal partners, which was surprising because businesses stand to benefit from improved community health and reduced sick time. Partnerships are advised to undertake extra efforts to recruit partners from the employer and health insurer sectors as principal partners of these initiatives.

PARTNERSHIP ORIGINS AND LEADERSHIP

A spark that ignited interest and prompted community leaders to consider collaborative efforts frequently led to the partnerships that were implemented. We identified three types of conditions that galvanized leadership actions to start coalitions. The first was a charismatic leader, like Art Nichols, CEO of Cheshire Medical Center/Dartmouth-Hitchcock, who was instrumental in the development of Healthy Monadnock 2020, a broad-based partnership in New Hampshire. The second was a health crisis that came to the attention of the community, such as the inner-city Detroit, Michigan, infant mortality rates that rivaled developing countries and prompted Detroit's competing health system leaders to create a joint task force dedicated to changing infant mortality statistics. The third was leadership ability to seize a grant-funding opportunity that incentivized collaborative initiatives to address documented community health issues. A greater understanding of these catalyzing forces can help other leaders identify key moments and circumstances for forging successful multisector community health partnerships.

In all partnerships a trusting, long-standing relationship between major actors in the

community was key to success. Without that trust and strong social capital, it would have been difficult for any of these initiating factors to result in the successful partnerships we studied. We also observed that although charismatic leadership was involved in establishing many of the partnerships, leadership tended to evolve over time to more of a servant-leadership model, a concept first described by Greenleaf and Spears,[5] in which the leaders put the needs of others first and shared power. This was not surprising because so much of the work is accomplished by volunteers, through consensus-building, and through influence, rather than by authoritative dictates. A servant-leadership approach was an important attribute of the leaders of the partnerships.

MAINTAINING A CLEAR MISSION FOR INITIATIVES

All the successful partnerships we studied had clear mission statements, although they varied in length and format. Each mission focused on improving the health of the community; some were very specific, such as reducing infant mortality, and some were broad, such as becoming the "nation's healthiest community by 2020." Although all partnerships had major challenges, those with broad missions faced the more difficult challenges and may not have understood these challenges and the difficulty of implementing changes across a variety of sectors, settings, and activities when they began.

Some partnership representatives did not fully recognize the importance of building a clear understanding of population health concepts among all partners involved.[6] All partnerships in the study were committed to ongoing review of the mission statements, which we recommend to ensure partnership success and sustainability in the changing relationships within and between the multiple sectors involved in population health.

FINANCIAL SUPPORT AND SUSTAINABILITY

Some of the partnerships we studied were financially fragile and lacked the long-term resource commitment that would ensure their continued functioning. The majority of local funds for these programs originated from the hospitals that supported the coalitions, usually as a part of their community benefit activities, as was the case with MaineHealth's development of the HOMEtowns Partnership. Some partnerships were grant supported, but because grants specify program spending and are time-limited, sustainability plans were needed to continue activities when the grant support ends.

In some cases the county authority or public health department provided funding support as the anchor institution of the partnerships, allocating funds for staff time and other operational activities such as Web site, telephone, and clerical support, as occurred for example in Healthy Montgomery (in Maryland). Again, we noted the unexpected absence of core support from health plans and major employers, with the exception of Kaiser. Because sustainability funding was an issue for every partnership studied, and even with the heavy reliance on volunteer labor, all partnerships are encouraged to constantly develop strategies for broadening and diversifying their sources of funding support.

COMMUNITY RECOGNITION AND PERFORMANCE REPORTING

Although all the partnerships we studied were well established and appreciated by the principal partners and other participants, they often lacked recognition in their larger local communities. The participating hospitals, health departments, and other partners were well known in their communities, whereas some partnerships were not. Several used various communication mechanisms to inform their communities of their accomplishments, but all admitted that much more needed to be done to raise the visibility of the partnerships.

Measuring partnership performance and improvements in community health was a particular challenge for some partnerships we studied, because "population health" has different meanings to different people and logic models for community health improvement and initiatives are still evolving. In all cases, the partnerships adopted measures and metrics to monitor their success and improve performance as needed. Some partnerships reported struggles with defining metrics and obtaining data to measure progress on their objectives. Some were able to track only process measures and had not yet advanced to tracking more specific community health status outcome measures. These observations illustrated that to enable objective, evidence-based evaluation of a partnership's progress in achieving its mission and goals and to fulfill its accountability to key stakeholders, the partnership's leadership must specify the community health measures they want to address, the particular objectives and targets they intend to achieve, and the metrics and tools they will use to track and measure progress.

Partnerships' accountability and reporting, both to key stakeholders and the community at large, will be strengthened by the use of community health measures that are linked to mission and goals. Additionally, if leaders use these specific metrics and data after identifying their objectives for community health, they will be better able to monitor and report the progress and value of their partnership. Through developing impact statements that engage the community, they will go a step further in demonstrating progress in achieving their health objectives. Because of the evolving nature of reliable population health metrics, the release of both the Institute of Medicine Vital Signs[7] and the Robert Wood Johnson Foundation's measures of a "culture of health"[8] research will be helpful in partnership reporting.

SUMMARY AND CONCLUSIONS

We have addressed the charge issued at the Keeneland Conference calling for the identification of successful partnerships among public health organizations, hospitals, and other stakeholders dedicated to improving local community health status. We have identified some effective models, and we have elucidated characteristics that seem to prompt their success.[2] However, it is important to recognize that ours is an initial effort. We are

aware of efforts that are occurring within funding agencies to develop more of these models and to highlight successful ones. We welcome that effort.

Our work demonstrates that a movement affecting many communities in the United States is afoot. The ACA and its requirements for nonprofit hospitals to create a community health needs assessment and propose improvement efforts in identified problems may have prompted this. This parallels efforts by health departments to prepare community health assessments and community health improvement plans in conjunction with applying for accreditation to the Public Health Accreditation Board. It is our sense that even without these external prompts, there was, is, and will continue to be a broad movement among a variety of community organizations to address their local health problems. Our work has, we hope, helped some of those communities that are just striking out in this effort gain valuable lessons that can be applied to their future development.

However, this growth should not be left to chance. There are several ways that local community efforts may be supported. To illustrate, we believe that all hospital and health system boards should form standing committees with oversight responsibility for their organization's engagement in examining community health needs, establishing priorities, and developing strategies for addressing them, including multisector collaboration focused on improving community health.[2] Similarly, local boards of health should act as a committee of the whole or create their own committees to work on creating and nurturing these community-wide partnerships.

In the course of our work, we examined two states where state health department advocacy had been successful in implementing initiatives to encourage hospital–health department partnerships: Maryland and New York.[9] Creative initiatives along these lines are underway in other states. Finally, we believe that the major national organizations representing health and health care should collaborate to foster duplication of these efforts in local communities through a variety of mechanisms. We believe there are communities all across the United States working, or planning to work, together to improve their communities' health. We must do whatever we can to ensure their success. AJPH

CONTRIBUTORS

F. D. Scutchfield, L. Prybil, and A. V. Kelly drafted and edited the commentary. All authors contributed to the conceptualization and design of the commentary.

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