Improving Community Health through Hospital – Public Health Collaboration

Insights and Lessons Learned from Successful Partnerships

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Foreword

Continuous improvement is the most pressing mandate in both public health and health care today. Achieving progress in this area requires us to exchange information on what works and what does not. And much of that information springs from opportunities to identify what we do not know.

One such opportunity presented itself in spring 2012. Public health researchers, practitioners and policy makers gathered for the annual Keeneland Conference sponsored by the National Coordinating Center for Public Health Services and Systems Research at the University of Kentucky College of Public Health and the Robert Wood Johnson Foundation. In a lunchtime presentation, Rich Umbdenstock, president and CEO of the American Hospital Association, pointed out, "As hospitals move from volume-based payments to value-based payments, they are much more concerned about the connection between population health and their own efforts to improve outcomes, care coordination, and prevention. From mobile vans and health screenings to education fairs, many hospitals have long been active in efforts to improve the health of the population they serve."

A discussion followed. Rich, Bobby Pestronk, executive director of the National Association of County and City Health Officials, and Paul Jarris, executive director of the Association of State and Territorial Health Officials, talked about the nationwide need for better communication and more collaboration between the hospital and public health sectors to improve population health. And they expressed a desire to make more examples of successful collaborations from across the country available to their colleagues.

Enter Dr. Larry Prybil, Norton Professor in Healthcare Leadership, and Dr. Doug Scutchfield, Bosomworth Professor of Health Research and Policy, at the University of Kentucky. With Larry's experience as a hospital and health system executive and Doug's expertise in public health services, they responded to the discussion with action. Over the following months, they convened experts in health economics, health law and statistics, as well as individuals with leadership experience in the public health and health system sectors. This multi-disciplinary team developed an innovative approach to studying this important topic.

We are excited that, under Dr. Prybil's guidance as project director, the team found that collaborations between the hospital and public health sector not only exist but are effective in improving the overall health of communities. This report, including its conclusions and recommendations, is worthy of the attention of every public health, hospital, and community leader with a desire to improve the health of America's communities — and what this means for all of us.

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Table of Contents

Section I.	Introduction	3
Section II.	Purpose and Methodology	5
Section III.	Study Findings	10
	• Origins	10
	• Organizational Models	12
	• Mission and Plans	16
	• Partnership Management	17
	• Performance Evaluation	18
	• Challenges	23
	• Sources and Levels of Support	26
	• Emerging Patterns and Selected Features	28
	• State-Level Initiatives to Promote Hospital – Public Health Collaboration	36
Section IV.	Conclusions, Recommendations, and Closing Remarks	38
Section V.	Acknowledgments	46
Appendix A	Core Characteristics of Successful Partnerships	49
Appendix B	List of Nominated Partnerships	52
Appendix C	Selected Features of the Participating Partnerships	64
Appendix D	End Notes	100

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Section I. Introduction

Health care expenditures in the United States currently consume over 17 percent of the nation's gross domestic product, a much larger share than other developed nations.[1] Yet, despite this large investment, studies by Commonwealth Fund, the Institute of Medicine, and other organizations show the USA lags behind other developed nations on multiple metrics of population health such as infant mortality and life expectancy.[2] Moreover, there is extensive evidence of disparities in access, cost, and quality of health care services.[3]

Thus, we are confronted by a striking paradox: the USA spends a large and growing proportion of our resources on health care, but the outcomes in terms of access to services, the quality of those services, and the health of our population do not match other countries whose spending per capita is lower. It is evident that many factors contribute to this paradox — demographic, environmental, genetic, lifestyle, and socioeconomic — and all warrant societal attention.[4] Improving access to outpatient and inpatient medical services and the quality of those services, while important, cannot resolve the paradox.

Across the country, there is growing awareness that restraining the increase in health expenditures and improving the health status of families, communities, and society at large will require a broader approach that addresses the full array of factors affecting health status. Greater attention and resources must be devoted to promoting a safer environment, healthy lifestyles, prevention of illnesses and injuries, and early detection and treatment of health problems, as well as dealing with the underlying determinants of health.[5] This approach necessitates integrating basic principles of public health into organizing and delivering health and medical services.[6]

To effectively design, implement, and sustain a comprehensive approach to promoting the overall health of given communities and populations, better communications and collaboration among health delivery organizations, the public health sector, and other key community stakeholders is imperative. In the past, the levels of mutual understanding and coordination too often have been weak.[7] Now there is growing awareness of the need for better communication and collaboration directed at improving community health and doing so with greater efficiency. Illustrations of this awareness include:

- The Patient Protection and Affordable Care Act (2010) included a broad set of provisions aimed at payment and delivery reform. One of the Act's provisions resulted in Internal Revenue Service requirements for tax-exempt hospitals to conduct, at least every three years, a *community health needs assessment* (CHNA) with input from persons who represent the broad interests of the community, develop an *implementation strategy* to address priority needs identified through that process, and make them widely available to the public. In seeking input, the hospital must take into account input from several sources including at least one state, regional, or local public health department or its equivalent agency. The IRS now acknowledges that *multiple* hospitals may collaborate in conducting their CHNA so long as an authorized body of each hospital (e.g., the hospital's board of directors) adopts a *joint* CHNA report that is produced for all of the collaborating hospitals.[8] With Public Health Accreditation Board (PHAB) standards also calling for local health departments to conduct or participate in *collaborative* processes for assessing, prioritizing, and addressing community health needs, there now is an extraordinary opportunity for mutually beneficial cooperation among hospitals, public health departments, and others who share commitment to improving community health. It is hoped that hospital and health department leaders seize this opportunity and collaborate in bringing about transformational change, rather than simply complying with IRS regulations.[9]

- A series of major reports in recent years by prominent organizations including the Institute of Medicine,[10] The Trust for America's Health,[11] and the Robert Wood Johnson Foundation[12] have emphasized the importance of closer linkages between health delivery organizations and the public health sector as a key strategy for improving community health and restraining health care expenditures. Reports such as these — together with growing media attention on the health status of the American population and our nation's health care expenditures compared to other developed countries — have increased mainstream recognition of the need for change.
- National hospital and public health associations including the American Hospital Association, the Association of State and Territorial Officials, the Association for Community Health Improvement, the Catholic Health Association, and the National Association of County and City Health Officials also have acknowledged the need for more collaboration between the hospital and public health communities. In this context, the President and CEO of the American Hospital Association, Richard Umbdenstock, has stated "It is important to identify critical interfaces between 'public health' and 'acute medical care' and open a new mutually beneficial chapter in dialog and collaboration between the hospital and public health communities."[13]

In short, there are serious concerns in the USA regarding access, cost, and quality of health care services and the health status of our population in relation to other developed countries. There also is growing recognition within the public and private sectors that our health delivery system's traditional focus on the needs and treatment of individual patients, while worthy, is inadequate in itself and that greater attention must be devoted to "population health" approaches. These are approaches designed to assess, improve, and maintain health throughout entire communities or defined population groups such as all enrollees in a health plan, rather than focusing only upon the care and treatment of individuals.[14] There is growing agreement that improving our nation's health care enterprise requires concerted, sustained focus on three aims: increasing the quality and experience of patient care, reducing the per capita costs of care; and improving the health of defined populations — the so-called "Triple Aim."[15] Finally, there is substantial evidence that better communications, cooperation, and collaboration among hospitals and health systems, public health departments, and other community organizations and groups are needed to achieve these aims.[16]

These three issues — concerns about the historical performance of America's health system, the need to supplement the system's traditional focus on caring for individual patients with greater attention to improving population health, and the importance of improving communications and collaboration within the system — provided the impetus for this study.

Section II. Purpose and Methodology

Purpose and Objectives of the Study

In many sectors of the American economy, the complexity of societal issues and resource constraints are demanding innovation, creative strategies, and collective action by traditionally independent organizations.[17] In the health sector, it is increasingly apparent that the daunting challenges involved in improving the overall health status of communities and population groups will require new models of collaboration among hospitals, public health agencies, and other parties.[18] Unfortunately, while there is evidence of some increase in recent years,[19] there is broad consensus that decades of limited communications, lack of mutual understanding, and incongruent goals have inhibited collaboration between hospitals and public health departments in many communities across the country.[20]

This study is intended to accelerate change, encourage collaboration, and contribute to building a "culture of health"[21] in American communities. The overall purpose of the study is to ***identify and examine successful partnerships*** involving hospitals, public health departments, and other stakeholders who share commitment to improving the health of communities they jointly serve and ascertain ***key lessons*** learned from their collective experience. The study's objectives are to:

- ***Locate*** collaborative partnerships including hospitals and public health departments that are focused on improving community health;
- ***Identify*** a set of these partnerships that have been in operation for at least two years, have demonstrated successful performance, and are diverse in location, form, and focus;
- ***Examine*** these partnerships to gain knowledge about their genesis, their organizational arrangements, their goals and how progress is assessed, and the lessons learned from their collective experience; and
- ***Produce*** information and insights that will assist leaders of public and private organizations and policy makers in building strong, successful partnerships designed to improve community health.

Methodology

The methodology for this study includes five phases. First, identifying core characteristics of durable, successful partnerships; second, locating and inviting participation in this study by partnerships involving hospitals and health departments that meet several baseline criteria; third, assessing these partnerships against core characteristics of successful partnerships and identifying those that, based on available information, appear to be successful and diverse; fourth, conducting site visits to a selected set of these partnerships to generate comparable information from partnership representatives and official documents; and finally, analyzing this information to determine key findings, conclusions, and insights.

In brief, these phases can be described as follows:

Phase One: Identifying core characteristics of successful partnerships. "Partnerships" can take many forms, from informal alliances to formal corporate structures, but all involve the engagement of two or more parties — individuals, groups, or organizations — who agree to work together to achieve a common purpose. Organizing and operating all forms of partnerships and alliances is challenging; a significant proportion do not succeed.[22]

However, a large number of research studies and operational experience in a broad range of settings have produced a large body of information regarding the reasons partnerships are established, the factors that influence their performance, and the characteristics of successful partnerships. Based on this foundational work in the public and private sectors and with special attention to studies involving health-related organizations,[23] the research team developed a framework that embodies the most widely accepted characteristics of successful partnerships along with specific indicators of each characteristic. The complete document is contained in **Appendix A**; the eight core characteristics are:

- **Vision, Mission, and Values** - The partnership's vision, mission, and values are clearly stated, reflect a strong focus on improving community health, and are firmly supported by the partners.
- **Partners** - The partners demonstrate a culture of collaboration with other parties, understand the challenges in forming and operating partnerships, and enjoy mutual respect and trust.
- **Goals and Objectives** - The goals and objectives of the partnership are clearly stated, widely communicated, and fully supported by the partners and the partnership staff.
- **Organizational Structure** - A durable structure is in place to carry out the mission and goals of the collaborative arrangement. This can take the form of a legal entity, affiliation agreement, memorandum of understanding, or other less formal arrangements such as community coalitions.
- **Leadership** - The partners jointly have designated highly-qualified and dedicated persons to manage the partnership and its programs.
- **Partnership Operations** - The partnership institutes programs and operates them effectively.
- **Program Success and Sustainability** - The collaborative partnership has been operational for at least two (2) years, has demonstrated operational success, and is having positive impact on the health of the population served.
- **Performance Evaluation and Improvement** - The partnership monitors and measures its performance periodically against agreed upon goals, objectives, and metrics.

Phase Two: Identifying partnerships and inviting them to participate in the study. When this study was instituted in September 2013, there was no existing list of partnerships including hospitals and health departments focused on improving community health that met the baseline criteria of being in operation for at least two years and demonstrating successful performance. To locate such partnerships, the research team (1) developed a nomination form that requested substantial information about partnerships including their origin, mission, organization, and operations, (2) pre-tested the form with selected leaders in the hospital and public health communities, and (3) sought the assistance of national associations in announcing the study and inviting nominations. The associations' response was positive and, during September-November 2013, announcements of the study — together with instructions and encouragement to submit nominations — were distributed to their respective constituencies by AcademyHealth, the American Hospital Association, the American Medical Association, the Association of State and Territorial Health Officials (ASTHO), the ASTHO-Duke University Study Group, the Association for Community Health Improvement, the Catholic Health Association, the Centers for Disease Control and Prevention, the National Association of County and City Health Officials, several state and metropolitan hospital associations, and the Public Health Practice-Based Research Networks. In addition, the research team scanned current literature and contacted the ASTHO Primary Care and Public Health Integration Project to identify partnerships that appeared to meet the baseline criteria and facilitated their nomination.

The nomination process was curtailed early in December 2013. By that time, over 160 nominations had been received. After review by the team, it was determined that 157 nominations included complete or nearly complete information, appeared to meet the baseline criteria, and warranted further assessment and consideration. This population included partnerships located in 44 states. For a list of these partnerships, see **Appendix B**.

Phase Three: Indentifying highly successful partnerships. Screening and assessing the 157 nominations involved a multi-step process. **First**, four members of the team screened the nominations and excluded from further consideration those whose activities were limited to community needs assessment and/or providing educational programs. This process eliminated 94 partnerships from further consideration in this study. The persons who nominated these partnerships were notified and thanked.

In the **second** step, leaders of the 63 remaining partnerships were contacted, updated on the assessment process, and invited to complete and submit *supplemental* information focused on their partnership's goals and the metrics currently employed to measure their partnership's performance in relation to them. Satisfactory information was obtained from 55 of the 63 partnerships, and these were advanced for further consideration.

Third, five members of the team independently reviewed and rated these 55 partnerships on a four-point scale with defined criteria.[24] The partnerships were scored, and the results were compiled and reviewed by the five team members; the outcome was that 30 of the 55 partnerships were advanced for further consideration. The leaders of partnerships that were not selected were notified and thanked for their interest and participation.

In the **fourth** step of the process, four members of the team and two members of the study's National Advisory Committee independently reviewed and rated the 30 remaining partnerships using a three-point scale with defined criteria.[25] The results were compiled, reviewed by the six persons who participated in the rating process, and 17 of the 30 partnerships were selected for further consideration as possible locations for in-depth study including site visits. Based on all information available to the research team, it appeared that these 17 partnerships showed solid evidence of being "highly successful" in relation to our core measures of successful partnerships (see **Appendix A**). The leaders of partnerships who were not selected for further study were notified and thanked for their interest and participation.

The proposal for this study funded jointly by three organizations called for studying in-depth "up to ten" highly successful collaborative partnerships, including site visits. In consideration of the results of the final rating process and the team's interest in ensuring *diversity* in the partnerships' geographic location, structure and focus, the study's principal investigator and co-principal investigators — in consultation with members of the research team and National Advisory Committee — selected ten of these 17 partnerships as candidates for further study in March 2014. Subsequently, when it became clear that available funds would permit more than ten site visits, the study population was expanded by including two additional highly-ranked partnerships from the 17 finalists.

Thus, the study population ultimately included 12 partnerships located in 11 states. They are:

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

Phase Four: Planning and conducting site visits to a selected set of highly successful partnerships focused on improving the health of the communities they serve. Requests to leaders of the 12 partnerships in the study population were extended in the spring of 2014. All agreed to allow the research team to study their partnerships and, subsequently, two-day site visits to all 12 locations were arranged.

The intent of the site visits was to supplement information obtained in advance and learn at first-hand the views of partnership leaders and other participants regarding the partnerships' origins, organization, priorities, operations, and plans. In preparation for the site visits, a standard set of materials was requested from each partnership; e.g., affiliation agreements, current organizational charts, current planning documents, etc.

Prior to each site visit, information about the partnership compiled during the nomination and assessment processes was entered into a "Data Collection Guide." During the site visits, this tool provided a framework for entering comparable information obtained from official documents *and* from structured interviews with partnership leaders and small group discussions. Team members' experience in leading previous studies involving site visits and collecting information from official documents and structured interviews was helpful in designing an efficient and workable tool.[26]

The research team conducted two-day site visits to the partnerships in the study population during April-June 2014. Eleven of the 12 site visits were conducted by two team members, one by a single team member. The principal investigator participated in 11 of the 12 site visits; all co-principal investigators participated in one or more of them. During the site visits, individual interviews were conducted with all 12 partnership directors. In addition, 55 senior representatives of principal organizational partners were interviewed; because of scheduling considerations, four of these 55 interviews were conducted in part or entirely via conference calls.

To obtain additional input and perspectives, 21 small group discussions also were held involving a total of 145 persons with substantial and varied types of involvement in the partnerships' programs and activities; e.g., serving on committees and/or work groups and assisting partnership directors in various partnership activities. Both the individual interviews and small group discussions generally were 1.5 to 2.0 hours in length.

While on site, team members also met with partnership staff to augment information obtained from partnership documents, interviews, and group discussions. All of the partnership leaders interviewed individually were assured of confidentially. Both these persons and those who participated in small group discussions were cooperative, cordial, and straightforward. They also expressed high interest in learning the results of this study to enhance their own efforts to improve the health of their communities.

In addition, the research team identified two states — New York and Maryland — in which there are state-level initiatives intended to promote hospital–public health collaboration and examined these initiatives by reviewing key documents and interviewing senior officials.

Phase Five: Processing, tabulating, and analyzing data. In the process of reviewing the completed Data Collection Guides after the site visits, follow-up contacts were made with partnership leaders and staff personnel when information was missing or unclear. Subsequently, the interview data were entered into a Project Database and independently verified by another member of the research team.

After verification, the data were compiled and tabulated. In doing so, the "data" about the partnerships were transformed into "information." Subsequently, the research team examined this information and, through qualitative analysis, determined findings, identified overall patterns, and formulated conclusions and recommendations.

Limitations of the Study

This study was designed specifically to locate and examine *successful* partnerships that include hospitals, public health departments, and other parties focused on working together to improve the health of the communities they jointly serve. For the purpose of this study, the core characteristics of successful partnerships outlined earlier in Section II and presented in **Appendix A** were used as the benchmarks for identifying "successful partnerships." There are, of course, other benchmarks or criteria that could have been employed to make these selections.

The findings and conclusions presented in this report relate directly to the set of partnerships (12) that were selected to serve as the study population; they cannot be generalized to the many other partnerships around the country, formal and informal, that involve hospitals and public health departments.

From official partnership documents and publicly-available sources, the research team sought to obtain, record, and report *factual* information about the partnerships that were nominated and selected to be included in this study population. However, this is essentially a qualitative study and much of the information presented in this report is based on the views of partnership leaders, staff personnel, and other persons who participated in small group discussions. A structured interview guide was employed, and there were substantial follow-up communications after the site visits to clarify questions and obtain missing data elements. Also, information obtained from system documents were employed to supplement and, where possible, verify the interview data. However, the interview data represent the participants' perceptions and may not be factually correct in some instances. Opinion data have inherent limitations, and there are bound to be some inaccuracies in the team's interpretation and summarization of those data.

Section III. Study Findings

This study is intended to identify and examine a set of successful partnerships including hospitals, public health departments, and other parties that are working together to improve the health of communities they serve and ascertain lessons learned from their collective experience. This section presents information about the partnerships' origin and organization, mission and plans, management, performance evaluation, major challenges, and sources of support.

In addition, this section of the report describes overall patterns or "themes" that have emerged from this study and a description of a selected feature of each partnership in the study population.

Origins

This study examines partnerships that have demonstrated operational success. A baseline criterion for eligibility is that the partnership has been in existence for at least two years. Table 1 shows when the twelve partnerships in the study population were formally established. The oldest of these partnerships, Healthy Cabarrus based in Kannapolis, North Carolina, was established in 1998.

The genesis of these partnerships seem to be rooted in one or more of the following factors. **First**, *visionary and inspirational leadership* by one or more individuals in the community; for example, a Minneapolis Heart Institute physician, Dr. Kevin Graham, conceived the idea of a multi-year initiative to reduce heart attacks and improve community health in New Ulm, Minnesota — a community with high rates of heart disease — and secured a grant from Allina Health to support it. **Second,** a *community crisis* precipitating collective action to address it; for example, alarmingly high infant mortality rates in several inner-city Detroit neighborhoods galvanized the four healthcare systems that operate hospitals in Detroit to establish and provide financial support for the Detroit Regional Infant Mortality Reduction Task Force, an initiative that now includes multiple partners including public health agencies. **Third**, the availability of *grant programs* coinciding with clearly-identified community health needs and a public and/or private health organization with the capability to secure a grant, establish a solid partnership, and launch the initiative; e.g., the CDC Community Transformation grant program and joint leadership by the local health department (Public Health - Seattle and King County), Seattle Children's Hospital, and the Healthy King County Coalition in co-establishing a multi-faceted partnership directed at "Transforming the Health of South Seattle and South King County."

TABLE 1
Official Date of Establishment

Year	Number	Percent
Before 2004	2	17%
2004-2006	4	33%
2007- 2008	3	25%
2009-2012	3	25%
Total	**12**	**100%**

In several instances, the genesis of successful partnerships involved a confluence of these and/or other factors. In *all* cases, strong leadership by one or more dedicated individuals was essential. As shown in Table 2, all of the current partnership directors and 94 percent of senior representatives of principal organizational partners who participated in individual interviews readily identified a person or persons who provided *instrumental* leadership in founding their partnership and contributing to its success. In all cases, there was remarkable consistency in who they identified.

In addition, while more difficult to measure, in the origins in several successful partnerships was a tradition of community cooperation and/or a history of trust-based relationships among principal partners. In Cabarrus County, North Carolina, for example, the "collaborative spirit" that prevailed in this small county was pivotal in community-wide efforts to cope with the impact of its major employer, a textile plant, closing in 2003 *and* the evolution of the "Healthy Cabarrus" partnership to assist in meeting community needs that resulted from this devastating event. A strong relationship between leaders of the local public health authority (the Cabarrus Health Alliance) and the local hospital was critically important in the partnership's evolution *and* to its continued success since that difficult period.[27] Additional illustrations of the importance of trust-based relationships are present in St. Augustine, Florida, and Rockville, Maryland, where close, mutually supportive relationships among the local health department director, a senior executive from the hospital partner(s), and senior county officers have constituted a rock-solid foundation for the success of the "St. Johns County Health Leadership Council" in St. Augustine and "Healthy Montgomery" in Rockville.

TABLE 2
"Was there any person or persons who were critically important in the creation of the partnership?"

Response	Partnership Directors (n = 12)	Senior Representatives of Principal Partners (n = 49)*
Yes	100%	94%
No, not really	0%	0%
I'm Not Sure or No Response	0%	6%
Total	**100%**	**100%**

*Due to time constraints, 6 of the 55 interviews with senior representatives of principal organizational partners had to be focused on a prescribed set of broad, open-ended questions and did not cover this and several other specific, structured questions; see Tables 4, 5, 9, 10, 11, 12, and 13.

Organizational Models

Table 3 displays the current organizational models of these 12 partnerships. All have adopted and maintained comparatively informal structures. As yet, none have shifted to corporate structures and sought 501(c)(3) status from the IRS.

As shown by the information in Table 4, organizational changes have occurred in some of these successful partnerships since their establishment. The partnership directors and senior representatives of their principal partners report that *major* modifications have been made in the structures of two of the twelve partnerships since they were originally created. Less significant modifications have been made in *most* of the organizational structures since their inception; e.g., adding organizational partners, changing committee and task force structures, etc.

TABLE 3
Partnership Organizational Models

Models	Number	Percent
A tax-exempt corporation that is sponsored by, but distinct from, its sponsoring organizations.	0	0%
A formal, written affiliation agreement among all or several of the participating partners.	2	17%
A Memorandum of Understanding (MOU) among all or several participating partners.	1	8%
An informal "coalition" among all or several participating partners.	6	50%
Other models	3	25%
Total	**12**	**100%**

TABLE 4
"Has the current organizational model been in place since the Partnership was established, or has it been changed *substantially* since that time?"

Response	Partnership Directors (n = 12)	Senior Representatives of Principal Partners (n = 49)
Yes, it's been in place since the partnership was established	75%	78%
No, It Was Changed	17%	16%
Other or No Response	8%	6%
Total	**100%**	**100%**

It appears that partnership leaders have been able and willing to make changes in the organizational structure when indicated, and a substantial majority of them are comfortable with the partnership model that currently is in place. As shown in Table 5, a large proportion of the partnership directors and senior representatives of the principal organizational partners believe the current model is "highly effective;" almost none express dissatisfaction.

At the same time, most partnership directors and many of the senior representatives of principal partners are open-minded about the possible need for future organizational changes. There is broad recognition that organizational *structure* should be driven by organizational *strategy* and that — as the partnership's mission, goals, and strategies evolve in response to changing community needs and opportunities — the current organizational model may well need to be changed accordingly. For example, several partnership leadership teams envision the possible need to convert to nonprofit corporate status if and when there is a clear need to independently seek large-scale financial contributions from private citizens and/or business organizations.

In all sectors, most organizations — including those structured as informal alliances or coalitions — require a mechanism and process for establishing basic policies, setting direction, and addressing issues that arise. While their particular form, composition, and decision-making responsibilities vary considerably, 11 of the 12 partnerships in the study population have a body of this nature in place. They range from the board or board committee of a healthcare organization that serves as the partnership's "anchor institution"[28] (e.g., the MaineHealth Board of Directors for that system's broad-based community health improvement initiatives), to a partnership "committee" with a formal, written charter that defines its role, duties, and authority (e.g., the Community Board of the Quad City Health Initiative), to small, informal groups composed of the partnership's executive director and a few senior representatives of its principal organizational partners; e.g. the St. Johns County Health Leadership Council in St. Augustine, Florida.

TABLE 5
"From your perspective, how effective is the current organizational model?"

Response	Partnership Directors (n = 12)	Senior Representatives of Principal Partners (n = 49)
The current model is highly effective.	67%	59%
The current model is somewhat effective.	33%	33%
The current model is not very effective.	0%	0%
The current model has not been in place long enough to determine its effectiveness.	0%	0%
Other or No Response	0%	8%
Total	**100%**	**100%**

The size of these "policy and direction setting bodies" ranges from 44 to three members; the average size is 19. A total of 232 persons were serving on these bodies when site visits were conducted in the spring of 2014. By comparison, the average size of America's hospital and health system boards in 2013 was 14 members.[29]

Table 6 shows the racial composition of the partnerships' "policy and direction setting bodies." Three of the 12 had all-Caucasian memberships. However, for the 12 partnerships as a whole, 74 percent of the members are Caucasian and 26 percent are non-Caucasians. In America's hospitals and health systems, only 8 percent of the board members are non-Caucasian.[30]

Table 7 shows the composition by gender of the partnerships' "policy and direction setting bodies": 63 percent women and 37 percent men. One of the 12 partnerships has an all-female composition. The overall gender mix is a striking contrast to boards of the nation's hospitals and health systems where 77 percent of the members are men.[31]

Table 8 displays the occupational composition of the partnerships' "policy and direction setting bodies." A large proportion (45 percent) of members are in health professions, but both the business sector (15 percent) and the educational sector (9 percent) have a substantial presence.

While the specific functions, authority, and composition of these "policy and direction setting bodies" vary from location to location, it is clear that most serve an important role in their partnership's organizational model. As shown in Table 9, a majority of the partnership directors and senior representatives of the partnerships' principal organizational partners believe their "policy and direction setting body" is highly effective; many felt their approach could and should be improved, but *none* felt it was ineffective.

TABLE 6

Table 6: Racial Composition of Partnership Policy and Direction Setting Bodies

	Number of Members	Percent
Caucasian	171	74%
Non-Caucasian	61	26%
Total	**232**	**100%**

TABLE 7

Gender Composition of Partnership Policy and Direction Setting Bodies

	Number of Members	Percent
Women	147	63%
Men	85	37%
Total	**232**	**100%**

TABLE 8

Composition by Occupation of Partnership Policy and Direction Setting Bodies

Occupation	Number of Members	Percent
Hospital and Health System Managers	37	16%
Business Sector	35	15%
Public Health Professionals*	30	13%
Physicians	27	12%
Education Sector**	21	9%
City and County Administrators and Council Members	12	5%
Nurses	9	4%
Other organizations and occupations ***	61	26%
Total	**232**	**100%**

* Excluding physicians and nurses
** Including elementary, secondary, and college level
***Including persons affiliated with community-based health and social services agencies; employees of recreation, transportation, and other governmental units; health plans; and other organizations.

TABLE 9

"From your perspective, how well does your policy-setting body work?"

Response	Partnership Directors (n = 12)	Senior Representatives of Principal Partners (n = 49)
The current model is highly effective.	67%	59%
The current model is somewhat effective.**	33%	33%
The current model is not very effective.	0%	0%
The current model has not been in place long enough to test its effectiveness.	0%	0%
Other or No Response	0%	8%
Total	**100%**	**100%**

**The research team concluded that one partnership's "policy and direction setting" approach was too informal and infrequently used to consider it as an actual "body." The partnership director, however, felt it did exist and believes it has been "somewhat effective."

Mission and Plans

In essence, the fundamental mission of all 12 partnerships in this study population is to improve, in some way, the health of the communities they serve. The scope and focus of their *specific* missions, however, vary widely. To illustrate, the present mission of the Detroit Regional Infant Mortality Reduction partnership is to collaboratively address and reduce infant mortality rates in three inner-city neighborhoods — a very challenging but clearly-defined goal — while, toward the other end of the spectrum, the mission of Healthy Monadnock 2020 in New Hampshire is "To make the Monadnock region the *healthiest community in the nation* by 2020 through engagement of champions (partners, organizations, schools, and individuals) working to make the healthy choice the easy choice" — a very bold and comprehensive aspiration, indeed.

A concise description of all 12 partnerships — including a synopsis of their mission — is provided in **Appendix C** together with a particular partnership feature their leadership teams selected to showcase in this report. These overviews demonstrate clearly the breadth and variety of the partnerships' missions. However, they are quite consistent in two ways: first, they all focus directly on important community needs and, second, they all face *daunting* challenges.

Effective organizational leadership calls for mission statements, regardless of their scope and complexity, to be amplified by a "strategic plan" that translates the mission statement into a more tangible plan of action.

Before or during the site visits, ten of the 12 partnerships were able to provide the research team with documents that, in the team's opinion, fully or substantially meet standard criteria for "strategic plans." While a variety of "titles" were used for these documents, they all depict, in some form, the goals the partnership leaders and their principal partners intend to achieve in order to fulfill its mission, discuss core strategies and/or actions they believe will be needed to accomplish those goals, and provide some indication of how the partnership's performance in relation to those goals will be assessed. As reflected by the information presented in Table 10, a large majority of partnership directors and senior representatives of principal organizational partners agreed with the research team that ten of the partnerships actually have "strategic plans" in place while two, at this time, simply do not.

TABLE 10
"Does the partnership have a written 'strategic plan' or other such document that spells out the partnership's mission and the partners' vision for its future development?"

Response	Partnership Directors (n = 12)	Senior Representatives of Principal Partners (n = 49)
Yes	83%	78%
No, not in a formal written form	17%	20%
I'm Not Sure or No Response	0%	2%
Total	**100%**	**100%**

For the ten partnerships that, at the time of the site visits, had a "strategic plan" in a reasonably complete form, the partnership directors and senior representatives of principal organizational partners were probed to ascertain their individual views on the partners' level of support for the partnership's mission and vision as stated in that document. In response, nine of the ten partnership directors (90 percent) and 75 percent of the senior representatives of principal partners expressed that, in their opinion, the partners' overall support was "very strong."

However, during the formal interviews and in subsequent informal discussions, many of the partnership directors and representatives of principal partners expressed the view that their partnership's "strategic plans" need to be updated and sharpened with respect to goals, objectives, and evaluation protocols. In several instances, the "plans" had been created at the inception of the partnership or in connection with seeking grant support and had not been comprehensively reviewed and revised since that time. In virtually all of those conversations, common themes were (1) recognition that the "plans" needed to be reviewed, updated, and improved in content and format and (2) limitations of partnership staff resources and completing more time-urgent priorities had led to delays in this important work.

Partnership Management

The organizational settings for these 12 successful partnerships are diverse, and their settings have a major impact upon the staff resources the partnerships enjoy. Several partnerships are based in or closely connected to strong organizations that constitute "anchor institutions" for the partnerships; e.g., Kaiser Foundation Hospitals and Health Plan is the home base for Kaiser's system-wide "Community Health Initiatives" program; MaineHealth, a Portland-based nonprofit health system, is the principal sponsor for "HOMEtowns Partnership" which also involves numerous other communities and organizational partners in Maine; and the "St. Johns County Health Leadership Council" in Florida and "Healthy Montgomery" partnership in Maryland (and other partnerships) are closely aligned with strong local health departments and are able to draw support from them.

On the other hand, some partnerships are more independent and, thus, more reliant upon resources they generate from multiple sources. For example, "Healthy Monadnock 2020" in Keene, New Hampshire, has been successful in engaging a broad range of community organizations and groups and enjoys an excellent relationship with the local hospital, Cheshire Medical Center/Dartmouth-Hitchcock. However, it does not receive the level of direct financial support that some anchor institutions provide to the partnerships with which they are affiliated.

Still, all 12 partnerships do have a person who serves as the partnership's "executive director" (the titles vary) and devotes all or a significant portion of their work time to this role. Some have substantial management and technical support, others do not. In most of the partnerships, however, the partnership director is invested with limited or no *formal authority* over the organizational partners or the other organizations, groups, and individuals who are affiliated with the partnership and upon whom the partnership is dependent for time, energy, and other resources. Thus, the directors must be capable and comfortable with planning, managing programs and people, and "making things happen" through dedication, influence, and persuasion, rather than authority. This is particularly essential due to the fact that virtually all of these successful partnerships rely heavily upon volunteers to constitute the array of task forces, sub-committees, and work groups who actually do much of the community-based, day-to-day work that is essential to accomplishing the partnership's goals. In a sense, the role and challenges of a partnership director are similar to those involved in managing nonprofit associations with large cadres of voluntary workers.

In most instances, the partnership director's role is short on resources and formal authority and long on challenges and work load. This is a combination that many people cannot handle well and is a major reason why several of these successful partnerships have experienced turnover in senior management. According to the current partnership directors and senior representatives of principal organizational partners, five of the 12 partnerships (42 percent) have appointed new partnership directors in recent years.

However, it is very clear that the role of partnership director is vital to the short-term and long-term success of these partnerships, that their work is both challenging *and* extremely rewarding, and that, at this time, these twelve successful partnerships are benefitting greatly from the dedicated and skillful leadership of the present directors and their support staff. Virtually without exception, the senior representatives of principal organizational partners and the many other partnership participants with whom the research team interacted during and after the site visits greatly admire, appreciate, and respect the partnership directors and their teams.

Performance Evaluation

The health of a community or population group is determined by a complex array of factors, including the economic, physical, and social environment and the citizens' biology and lifestyle as well as their access to clinical health services and the quality of those services. It is abundantly clear that the overall health of a community or population group depends more on the factors external to the health system than those within it.[32] As expressed by Paula Lantz, Richard Lichtenstein, and Harold Pollack, "…participants in health policy must remind citizens and policy-makers that lack of access to health care is not the fundamental cause of health vulnerability or disparities in health."[33] However, in America, hospital and medical services continue to account for the *major* share of our nation's health expenditures.

The leaders of the partnerships in this study population understand that a broad matrix of factors interact to determine the overall health of the communities they serve and that, to have impact, they must purposefully select the factor or factors they wish to address, the strategies they will employ, and how they will measure the results of their efforts. These are difficult issues with no easy or simple solutions.

With respect to the determinants of health they will strive to address, each partnership has had to establish priorities and make hard choices. To assist in making these decisions, all partnerships have studied and tried to prioritize community needs. As reflected by the information in Table 11, both the partnership directors and senior representatives of principal organizational partners believe that assessing and prioritizing their community's needs have been *instrumental* in shaping their partnership's focus and functions. Moreover, as shown in Table 12, nearly all of the partnerships routinely collaborate with other community organizations in the process of assessing and prioritizing their community's health needs.

TABLE 11
"Are [your] partnership's programs based on objective assessment and prioritization of community need?"

Response	Partnership Directors (n = 12)	Senior Representatives of Principal Partners (n = 49)
Yes, the linkage is very strong; these programs were established as a direct outcome of formal, objective community needs assessment.	83%	76%
Community needs were given consideration in the process of developing these programs.	17%	20%
No, not really.	0%	0%
I'm Not Sure or No Response	0%	4%
Total	**0%**	**100%**

TABLE 12
"Does your partnership assess and prioritize community needs in collaboration with others?"

Response	Partnership Directors (n = 12)	Senior Representatives of Principal Partners (n = 49)
Yes, on a regular basis.	92%	78%
Not routinely.	8%	14%
I don't know or No Response	0%	8%
Total	**100%**	**100%**

In several instances, such as the Healthy Cabarrus partnership in North Carolina and the St. John's County Health Leadership Council in Florida, the partnership serves a *principal* leadership role in a community health needs assessment and prioritization process whose results are widely accepted and employed by other institutions, organizations, and groups throughout the community.

In most communities, prioritizing and selecting the specific need or needs on which the partnership will focus is challenging because the needs almost always outstrip available resources. In addition, at this point in history, there are imperfect linkages among (1) determinants of population health, (2) perceptions and definitions of "health needs," (3) measures of population health, and (4) the efficacy of interventions in affecting those measures.

In spite of these complications, 11 of the 12 partnerships have determined which of the array of community needs they will focus attention on, formulated objectives, and selected metrics to employ in assessing progress. The information shown in Table 13 demonstrates close accord between the partnership directors and the senior representatives of the principal organizational partners on these vitally important matters.

TABLE 13

"Are the partnership's objectives and the metrics by which progress toward them can be measured adopted by the partnership's policy setting body?"

Response	Partnership Directors (n = 12)	Senior Representatives of Principal Partners (n = 49)
Yes, this is done consistently	92%	86%
They are presented but not formally adopted	8%	4%
No, this is not done on a routine basis	0%	4%
I'm Not Sure	0%	6%
Total	**100%**	**100%**

The partnerships whose leaders have chosen to address a *single* community health need (e.g., the Heart of New Ulm Project's focus on reducing heart attacks and cardiovascular disease in their community) or a *narrow* set of needs on which to focus their efforts have a *relatively* less difficult challenge in setting objectives, developing or facilitating interventions directed at those needs, and selecting metrics to measure progress as compared to partnerships with a more expansive mission and focus (e.g., the Fit NOLA partnership in New Orleans whose mission is to "move New Orleans toward becoming one of America's most fit cities"). Comprehensive, far-reaching missions such as this obviously require a broader range of objectives, interventions, and metrics with *major* implications for the time and resources that will be required to make a measurable impact.

In these instances, several partnerships have chosen to embrace some or all of the 26 "leading health indicators" set forth in the current U. S. Department of Health and Human Services (HHS) ten-year plan for improving the country's health (see Table 14) or other long lists of metrics. Focusing on *any* community health need, making or facilitating concerted efforts to address it, monitoring progress, amending strategies when indicated, and making measurable impact is complex work that demands sustained efforts. To simultaneously address *multiple* community health needs and make positive impact on them is enormously difficult.

All 12 of the partnerships in this study population are committed to on-going evaluation as a basis for performance improvement, have established objectives related to their particular mission in improving the health of their community, and have adopted metrics to use in monitoring and assessing progress toward those objectives. However, as stated by the Institute of Medicine in its recent report entitled Toward Quality Measures for Population Health and the Leading Health Indicators, "…in many ways the use of measures of quality to improve population health is still in its infancy."[35] This reality — in combination with difficulties that are inherent in generating good, reliable data regarding progress in relation to multiple metrics and limited resources to support performance analysis — poses substantial challenges for the partnership directors, their policy bodies, and their principal partners. These and related challenges are discussed more fully in the next part of Section III.

TABLE 14
Leading Health Indicators - Healthy People 2020*

Topic	No.	Indicator
Access to Health Services	1	Persons with medical insurance
	2	Persons with an usual primary care provider
Clinical and Preventive Services	3	Adults who receive a colorectal cancer screening based on the most recent guidelines
	4	Adults with hypertension whose blood pressure is under control
	5	Persons with diagnosed diabetes whose A1c value is >9 percent
	6	Children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines
Environmental Quality	7	Air Quality Index (AQI) exceeding 100
	8	Children exposed to secondhand smoke
Injury and Violence	9	Fatal injuries
	10	Homicides
Maternal, Infant, and Child Health	11	All infant deaths
	12	Total preterm live births
Mental Health	13	Suicides
	14	Adolescents who experience major depressive episodes (MDE)
Nutrition, Physical Activity, and Obesity	15	Adults who meet current Federal physical activity guidelines for aerobic physical activity and muscle-strengthening activity
	16	Adults who are obese
	17	Obesity among children and adolescents
	18	Total vegetable intake for persons aged 2 years and older
Oral Health	19	Children, adolescents, and adults who visited the dentist in the past year
Reproductive and Sexual Health	20	Sexually active females aged 15 to 44 years who received reproductive health services in the past 12 months
	21	Knowledge of serostatus among HIV-positive persons
Social Determinants	22	Students who graduate with a regular diploma 4 years after starting 9th grade
Substance Abuse	23	Adolescents using alcohol or any illicit drugs during the past 30 days
	24	Adults engaging in binge drinking during the past 30 days
Tobacco	25	Adults who are current cigarette smokers
	26	Adolescents who smoked cigarettes in the past 30 days

*Healthy People 2020 Federal Interagency Workgroup. Healthy People 2020 LHI Topics. Retrieved on 10/08/2014 from http://www.healthypeople.gov/2020/leading-health-indicators/2020-LHI-Topics

Challenges

The partnerships that comprise this study population vary in their specific mission, focus, organizational model, and geographic location. However, all are dedicated to improving the health of the community(s) they serve and have demonstrated operational success. Through review of official documents, individual interviews with twelve partnership directors and 55 senior representatives of principal organizational partners and small-group discussions involving 145 other persons who are active participants in partnership programs, it is clear that *all* of these successful partnerships have encountered challenges during their start-up years and in their on-going operations. Among the most common and important challenges they have experienced are the following.

First, creating, organizing, and leading all types of "partnership" models is inherently difficult. While flexible, partnerships are not as organizationally durable as corporate models and a substantial proportion of all forms of partnerships do not succeed and survive.[36,22] This is particularly true for partnerships that include a large number of "partners" with various levels of engagement where the authority for decision-making can be diffuse and complex. Formalization of decision-making and resource allocation processes is possible, of course, and has been accomplished in some of the partnerships in this study population. In others there has not been readiness to take this step.

A **second** challenge that is inherent in partnerships — particularly relatively informal coalitions or alliances where many of the partners have not made substantial financial investments or legally-binding obligations — is creating and sustaining the partners' interest and engagement. For most of the partnerships in this study population, "improving community health" is *not* the core mission of key partners such as educational institutions, business firms, local government, civic organizations, and so on. Even for many (not all) of the hospitals and health systems that are closely aligned with these partners, their traditional mission has focused principally on the care and treatment of individual patients and sub-groups of former patients who require continuing follow-up attention; e.g., persons with serious diabetic conditions. With the exception of Kaiser Foundation Hospitals and Health Plan, MaineHealth, and a few others, the emergence of improving the overall health of the community as a major part of their mission and social role is a relatively recent development.[37]

Partnerships in the form of relatively informal coalitions, alliances, and consortia are susceptible to losing partners when major opportunities or problems arise in the partner's core business, a key leader is replaced, and/or when the leadership team concludes the partnership with which they have been affiliated is not being productive. Nurturing and enhancing the interest, engagement, and support of partners in all sectors of the community is vitally important and represents an *on-going* challenge for all of these partnerships.

A **third** and very fundamental challenge for *all* of these partnerships is the intrinsic difficulty of bringing about measurable improvement in the overall health of the community or population group they are serving. "Bending the curve" on overall measures of population health such as rates of infant mortality or obesity and the incidence and prevalence of cardiovascular disease is exceedingly difficult to accomplish and nearly always requires large amounts of time, resources, and carefully focused efforts.[38]

To make impact on one or more of the overall health measures, a partnership must select a set of factors that science has shown are linked to and drive the overall measure *and* for which there are evidence-based strategies and sufficient resources for the partnership and their partners to employ in addressing it. While incomplete and imperfect, there now exists a growing body of information on disease, injuries, and risk factors.[39] Selecting the overall health measure(s) a partnership wishes to address and the "intermediate" factors and related metrics on which the partnership will focus resources and efforts is quite challenging; however, making these selections is a financial and moral imperative for partnership leaders.

Resources for improving community health are scarce. They must be allocated to targets and strategies that are most likely to have a positive impact on high-priority health needs in the community. By (1) placing a disciplined focus on high-priority health measures and carefully selected intermediate factors and (2) demonstrating progress on a set of *key* metrics, the partnerships are more likely to build and maintain the interest and engagement of their partners, volunteers, and the community at large and, in doing so, generate support for continued efforts.

This leads directly to a **fourth** major challenge for most of these partnerships: securing sufficient and sustainable funding. In some instances, large, successful healthcare organizations with deep commitment to improving the health of the communities they serve have provided a high level of on-going support for their community health improvement initiatives and this has provided a solid financial foundation for them; e.g., Kaiser Foundation Hospitals and Health Plans and MaineHealth. For several partnerships, a strong health department has served as the "anchor institution" and provided a secure home for them; e.g., the Florida Department of Health in St. Johns County, the New Orleans Health Department, the Montgomery County (Maryland) Department of Health and Human Services, Cabarrus Health Alliance (the local health authority) in Cabarrus County, North Carolina), and Public Health - Seattle and King County. However, even in these instances, most of the partnerships must continuously seek additional sources of financial support and — given the scope and complexity of their mission — are lightly funded. Many have been successful in seeking external grant support from local, state, or national sources (e.g., CDC Community Transformation Grants and, more recently, CDC's new Partnerships to Improve Community Health Grants). However, these grants generally provide limited funding for relatively short periods of time, *and* they generally prescribe or have substantial influence on priorities and strategies. Being substantially dependent on external grant funding limits the ability of partnership leaders to take a long-term view in program development or staff support.

The limitations and uncertainties in funding support translate directly into a **fifth** challenge for most of these twelve partnerships; i.e., limited staff support for the partnership directors and heavy reliance on volunteers to perform a major share of the partnership's work. Obviously, the active engagement of community volunteers and staff members from organizational partners in partnership activities has many benefits and, in some ways, is a key to the success of these partnerships. Their interest and leadership on partnership committees, task forces, and ad hoc teams infuse the partnerships with energy and talent. The involvement of a broad cross-section of persons from many sectors also assists in building bridges between the partnership and the community, community spirit, *and* social capital.

At the same time, however, heavy reliance on volunteers necessitates on-going efforts by the partnership directors and, to the extent they exist, their full-time staff. A work force that is composed largely of volunteers, even when they are highly interested and dedicated, inevitably experiences substantial turnover. This reality creates a need for the partnership director to devote on-going efforts to succession planning and recruitment — another part of the staffing challenges that most of these partnerships must address in one form of another.

A **sixth** basic challenge for many of these partnerships is to build community recognition, credibility, and respect. With few exceptions, these partnerships are relatively small entities without a long history of community service. Moreover, they all have organizational partners — hospitals, school systems, etc. — that are much larger and well-known throughout the community. As a result, the partnership directors and their policy and direction-setting bodies are challenged to find appropriate ways to inform the communities they serve about their partnership's mission and the important work that the partnership — in collaboration with their partners — is doing for the community.

As shown in Table 15, one strategy that most partnerships are employing to build recognition and respect is providing information with the community at large in the form of press releases, regular progress reports, and presentations to community organizations and groups.

However, a very large proportion of the partnership directors and senior representatives of principal organizational partners, in their own words, express the belief that "we have a lot more work to do" in building community-wide recognition, understanding, and respect for their partnerships. Most also believe this is essential in building, over time, support by the business community and other sectors that will be required to build a solid, sustainable financial foundation for their partnership.

TABLE 15
"Is information about the partnership's programs, objectives, and progress toward their achievements shared with the community at large?"

Response	Partnership Directors (n = 12)	Senior Representatives of Principal Partners (n = 49)
Yes	84%	71%
No	8%	0%
Other or No Response	8%	29%
Total	**100%**	**100%**

Sources and Levels of Support

The twelve partnerships vary widely in the amount and types of financial resources received from principal partners and other sources to support partnership activities. The leanest partnership examined, Partnership J, operated with total direct financial support of just over $60,000 for its most recent fiscal year (Table 16), while the most highly capitalized partnership, Partnership D, received an average of $4.6 million per year in financial support over its 10 year history with a budget of $10.4 million in the most recent fiscal year. When each partnership's financial resources are scaled according to the size of the target population it serves, annualized resources vary from a low of 12 cents per capita in Partnership K to a high of $372 per capita in Partnership A — whose work is focused on a very small population group with extensive health and social needs. The median funding level across the 12 partnerships stood at $1.69 per capita for the most recent fiscal year. This heterogeneity in funding levels reflects key differences in the design and operation of each partnership, including the volume and intensity of activities supported, the fixed and variable costs associated with these activities, the size of the target populations served, and the mix of available in-kind non-financial resources.

TABLE 16

Levels of Funding for Most Recent FY and the Partnership Directors' Outlook for Funding Changes in the Next FY

Partnership	Annual Revenues ($ in 000s)	Revenue Per Capita	% Private Funding Sources	Next Year's Expected Change in Financial Support	Key Contextual Information
A	$745	$372.33	100%	Negative	Targeted initiative in single, small community. Hospital sponsored with major foundation funding.
B	$1,245	$93.83	89%	Negative	Targeted initiative in single, small community. Most funding from private hospital and insurer.
C	$275	$2.67	100%	Positive	Hospital sponsored and funded.
D	$10,435	$9.49	100%	Negative	Multi-community initiative; single funding source
E	$1,829	$3.82	0%	Negative	Fully federally-funded project.
F	$2,050	$5.95	42%	Mixed	Federally funded with some hospital funding.
G	$133	$0.71	21%	Stable	Local government funding directed to the health department.
H	$84	$0.40	64%	Unknown	Health department sponsored but funded through hospital and state government support.
I	$116	$0.36	100%	Positive	All private sources, primarily hospital funding.
J	$60	$0.16	100%	Mixed	Health department sponsored but foundation funded.
K	$125	$0.12	100%	Positive	Health department sponsored but funded by hospital.
L	$433	$0.15	0%	Negative	Multi-community initiative with full federal funding.

Most of the 12 partnerships use multiple funding sources to support their operations, with notable exceptions in Partnerships E and D that receive all of their funding from a single source. Private funding sources are the most prevalent source of financial support, with 10 of the 12 partnerships receiving at least some of their funding from nongovernmental funders. In total, the 12 partnerships received more than 78% of their funding from private sources (Table 17). Hospitals and health systems provided 89% of the private funding and 70% of the total funding for these partnerships. It is apparent that these hospitals and health systems are choosing to employ a considerable amount of their community benefit funds to support the partnerships with which they are affiliated.[40]

For the most recent fiscal year, four partnerships reported they had federal funding; two said they had state funding. By contrast, only 1 of the 12 partnerships reported receiving direct financial support from local government sources in the most recent fiscal year (Partnership G); it received nearly 40 percent of its total funding from this source. Notably, only 4 of the 12 partnerships (Partnerships B, F, G, and H) reported receiving funding from both government *and* private sources during the most recent fiscal year, indicating that the revenue streams for most partnerships are less than fully diversified.

TABLE 17
Sources of Funding for the Most Recent Fiscal Year

Source	Total Funding ($ in 000's)	Percent of Total Funding	Per Capita Funding	Number of Partnerships with Funding Source
Federal funding	$3,583	20.4%	$0.51	4
State funding	$85	0.5%	$0.01	2
Local public funding	$50	0.3%	$0.01	1
Private funding:	$13,790	78.7%	$1.96	—
Hospital/health system	$12,283	70.1%	$1.74	8
Foundations/other private	$1,507	8.6%	$0.21	6
Other funding sources	$21	0.1%	$0.00	1
All sources	$17,529	100.0%	$2.49	—

The limited financial diversity of the partnerships suggests that, over time, these initiatives may become vulnerable to financial instability due to changes in private markets, public budgets and spending priorities. This vulnerability is reflected in the financial outlook expressed by partnership directors. Leaders in 10 of the 12 partnerships anticipated substantial changes in the levels and/or sources of financial support for their activities over the next two fiscal years. As shown in Table 16, the leaders of five partnerships anticipated predominantly negative changes in financial resources, while three partnerships anticipated predominantly positive changes. Leaders in three of the remaining partnerships expressed mixed or uncertain financial outlook, with only one partnership expecting stable financing. It is important to note the financial data reported by the 12 partnerships provide only a partial view of partnership resources because they do not reflect the value of in-kind resources contributed to the partnerships, or resources expended by partners in support of partnership activities.

Emerging Patterns and Selected Features of the Partnerships in the Study Population

This section of the report has two parts. First, an overview of several overall patterns or themes that emerged from this study of 12 successful partnerships focused on improving community health and related literature. Second, a synopsis of one special feature of each partnership selected by the partnership's leadership team to be shared with the readers of this report.

Emerging Patterns

Each of the 12 successful partnerships that participated in this study is unique in certain respects. While all are dedicated to improving the health of the communities they serve, their genesis, their evolution in response to changes in their community and their particular mission, goals, and their strategies for addressing them vary considerably. However, these partnerships exist in a nation whose health enterprise is undergoing transformational changes that are impacting *all* of them. From this study of successful and diverse partnerships including interviews with members of their leadership teams and many other community stakeholders, several common patterns emerge. These patterns appear with consistency in these 12 partnerships which are located in eleven states across the country. They include:

1. **Increasing focus at the local, state, and national levels on "population health" and improving the health of communities.**

   The study of successful partnerships in eleven states focused on improving the health of the communities they serve has affirmed our team's belief that a fundamental change is occurring in the United States; i.e., a growing awareness that inadequate attention and resources have been allocated to prevention of illness and injuries, early diagnosis and treatment, and promotion of wellness. Public awareness has been stimulated by the dramatically high per capita health care expenditures and poor health outcomes in the United States compared to other developed nations and a series of landmark reports by the Commonwealth Fund, the National Academy of Sciences, the Robert Wood Johnson Foundation's Commission to Build a Healthier America, the World Health Organization's Commission on the Social Determinants of Health, and others.

   In a sector as large and complex as the health field, awareness of serious problems and need for new approaches do not translate swiftly into fundamental changes. As this point in time, America's health expenditures continue to be invested disproportionately "… in curing and managing diseases that could have been prevented with investments in prevention and population health."[41] However, there are encouraging signs of an emerging pattern that includes increasing recognition by the hospital and medical communities of the need for (1) greater attention to population health issues, (2) better communications and more collaboration with

the public health community, and (3) collective action rather than independent, uncoordinated efforts to address and improve community health.

This pattern, while not universally present, is manifested in many ways across the country; e.g., the growing emphasis being placed by the American Hospital Association, the Catholic Health Association, and many state and metropolitan hospital associations on population health and the importance of collaboration between the private and public sectors.[42] Another manifestation of this pattern is the identification of over 160 operational partnerships involving hospitals, public health agencies, and other community stakeholders in response to the announcement of this study and the invitation, with a fairly tight window of time, to participate. Time will tell, but — given the serious problems with U. S. health costs and outcomes relative to other developed countries *and* the growing pressures by the media, public and private payers, and society at large for improvement — it seems likely that the partnerships examined in this study can be viewed as pioneers and, perhaps, harbingers of the future. Thus, their collective experience can be of value to other organizations and communities who are considering or are in the process of developing collaborative partnerships.

2. Multiple factors can lead to the formation of collaborative partnerships intended to improve the health of their community.

While the genesis of these 12 partnerships differed, they typically involve one or more basic factors. First, the interest, inspiration, and drive of a visionary leader(s) who recognized an important community health need and generated the idea of forging a collaborative partnership to address that need. Some of these visionary leaders have been *physicians* such as Dr. Richard Phillis, who played a key role in creating the Quad City Health Initiative, and Dr. Kevin Graham, who was instrumental in initiating "Hearts Beat Back: The Heart of New Ulm Project;" some were *executives* such as Dr. Ray Baxter, George Halvorson, and Dr. Loel Solomon, who spearheaded the development of Kaiser's National "Community Health Initiative" and Art Nichols, CEO of Cheshire Medical Center/Dartmouth-Hitchcock, who envisioned and encouraged the creation of "Healthy Monadnock 2020" in New Hampshire; others were *public health professionals* such as Capitola Stanley, Fred Pilkington, and Gina Goff, who, in concert with local hospital leaders, were pivotal in creating the Healthy Cabarrus partnership in Cabarrus County, North Carolina.

A second factor that can drive the development of a collaborative partnership is a health crisis or traumatic event which crystallizes the need for concerted, collective action to address it. For example, as discussed earlier in this report, recognition of exceedingly high infant mortality rates in several inner city Detroit neighborhoods prompted collective action by the four health systems that provide health services in Detroit to organize and sponsor the Regional Infant Mortality Reduction Task Force. This partnership now includes the local public health agencies and dozens of other community organizations and groups in a broad-based effort that is making measurable progress in reducing infant mortality rates and improving the health and the lives of hundreds of young women and their children in those neighborhoods.

A third factor that has been important in the development of several partnerships is the availability of grant support — from private and/or public sources — that incentivizes collaboration in addressing defined community needs. A cooperative community spirit and/or a prior history of successful, trust-based collaboration involving key parties also have been helpful in providing a foundation for several of the partnerships in this study population. Finally, some of

the recently-established partnerships were stimulated by the Internal Revenue Service community needs assessment and strategy development requirements resulting from provisions of ACA and/or the Public Health Accreditation (PHAB) standards that call for *collaborative* efforts to identify, prioritize, and address community health needs.

In most instances, one of these factors or a *confluence* of them led to the establishment of the partnerships that exist today. For example, Lora Connolly in the California Department of Aging provided creative leadership in combining *federal funding* for chronic disease self-management education with *excellent relationships* that already had been built with two major California-based health systems to develop exemplary *state-wide* programs.

Regardless of the particular impetus, it is clear that the *common goal* was to improve the health of the community or a particular segment of it by combining community talent and resources in a collective effort that would be more effective than independent uncoordinated efforts.

3. The partnerships' mission statements all focus on improving the health of the community or communities they serve, but their specific focus and scope vary substantially.

While the length and format vary, each of the 12 successful partnerships in the study population has developed a "mission statement" that defines its overall purpose and, in several instances, provides supplemental information about it. Their missions are all directed toward improving the health of the particular community or communities the partnership serves, but they vary significantly in their nature and scope. They range from very focused ("Reducing infant mortality in three neighborhoods") to very expansive ("Becoming the nation's healthiest community by 2020)."

Clearly a partnership's particular focus and scope drive the complexity of their goals, strategies, and services. *All* of these partnerships face major challenges in their efforts to improve community health outcomes and status; those with a broad, expansive mission have an exceptionally daunting role. In some instances, it seems apparent that the partners do not, as yet, share a consistent, common understanding of "population health," how health status should be measured, the exact aspects of their community's current health status the partnership should strive to change, and/or the evidence-based targets for improvement they should strive to attain. This should not be surprising, given the inherent complexities involved in measuring *and* improving community health and the youth of many of these partnerships.

Among the partnership leaders, however, there is substantial accord that their mission statements — as well as their goals, strategies, and target-setting and evaluation processes — need on-going review and refinement. There also is broad agreement that, to be viable, a partnership's mission and vision must inspire and drive community support and be marketed effectively to community leaders and the community at large.

4. The active engagement of many partners in the establishment and on-going operations of collaborative partnerships is essential to their sustainability and success.

The principal partners in the 12 partnerships in this study population universally include a public health agency or agencies (with various titles such as department, district, and authority) and one or more hospitals or health systems. All of these partnerships have enlisted other organizations and groups, some serving together with health agencies and hospitals as *principal* partners with a high level of engagement, some in less prominent roles. City and county government units, school systems, and educational

institutions frequently are active participants. In several instances, these partnerships focused on community health improvement provide a venue for *multi-sector* cooperation for which there is no equal in the community.

A highly welcomed and beneficial feature of several of these partnerships is that it provides a platform for collaboration on a common cause — improving the health of their community — by organizations that otherwise are competitors. For example, both Dignity Health and Kaiser Foundation Hospitals and Health Plan are principal partners and strong supporters of the California Healthier Living Coalition. In the Quad Cities — a five city, two state (Illinois and Iowa) metropolitan area that bridges the Mississippi River, the two local health systems (UnityPoint Health - Trinity and Genesis Health System) both serve as principal partners in the Quad City Health Initiative (QCHI) and support it in many ways, including providing in-kind assistance and financial resources. The CEOs of both systems serve on the partnership's Community Board and play important leadership roles. Finding ways to collaborate on programs and initiatives that are important to the community while, at the same time, competing in other ways is not unique to partnerships focused on community health improvement such as QCHI.[43] It is, however, extremely beneficial for the partnerships and speaks loudly and clearly to other community leaders about the importance of its mission and programs.

On the other hand, while improvement of community health should be of great interest to local employers and health plans, few of the partnerships have local businesses as *principal* partners and — other than Kaiser Foundation Hospitals and Health Plan, which is the "anchor institution" for their National Community Health Initiatives — none have health plans that serve as principal partners or provide substantial financial support for them. In virtually all cases, local businesses do allow — and often encourage — their employees to participate in the partnerships by serving on committees, task forces, and informal work groups. This form of support is very important because, as noted earlier, most of these partnerships are lightly staffed and highly dependent on the efforts of volunteers to sustain their programs and services. However, the low level of engagement by local businesses and health plans as *principal* partners or by providing substantial financial support for these partnerships is a pattern that warrants concern and attention. These issues will be addressed further in Section IV of this report.

5. Many partnerships continue to be challenged in developing objectives and metrics and demonstrating their linkages with the overall measure(s) of population health on which they have chosen to focus.

Developing and adopting *common definitions* of "population health" and building logic models that clearly demonstrate the *linkages* among the multiple determinants of health, interventions and intermediate objectives, and their impact on overall health measures is vitally important work that is underway but incomplete.[44] The fundamental aim of every partnership we are studying is to *improve* the health of a specific population group. To assess a partnership's progress toward its goals and fulfill its accountability to stakeholders, the partnership leaders must adopt measures (intermediate and long-term), implement evidence-based strategies, compile pertinent data, and conduct sound, objective evaluation.

This is of course, a *very* complex and challenging process. As stated in a recent report by the National Quality Forum: "The state of available measures and data sources is an interesting mix of abundance, with hundreds of existing metrics and a vast array of data from many sources. Many organizations feel overburdened with measurement requirements, while others may be 'drowning in raw data' but not be able to effectively apply this data for measurement and decision-making… There are also significant *gaps* in the measures for population health improvement."[45]

In this context, it is not surprising that many of these worthy partnerships have encountered challenges in selecting objectives and metrics and assessing their progress in actually *improving* the health of the communities they serve. In several cases, partnerships have long lists of objectives and metrics, some of which are difficult to track and not closely linked to specific overall measures of population health they are striving to improve. Clear, well-reasoned priorities are essential. All partnerships need to evolve beyond tracking "participation" and "processes" to measuring and reporting *outcomes* and *impact*. This is difficult but will be necessary to maintain momentum and build long-term support. *All* of the partnership directors and their leadership teams recognize these issues and are committed to on-going review and improvement in this realm.

6. A large majority of the partnerships are organized in a loose affiliation or coalition model.

Several of the partnerships included in this study are based in or affiliated with a strong anchor institution; e.g., HOMEtowns Partnership which is closely aligned with MaineHealth. Most of the partnerships, however, are organized in coalition models with various forms of "policy and direction setting" committees rather than incorporated entities with governing boards that have fiduciary responsibility. Most of these partnerships are relatively young organizations and are breaking new ground. Many of the partnership leaders express the view that moving immediately to independent tax-exempt corporate status in the beginning probably would not have been well-received in the community. While the current organizational models and policy-setting bodies are working, there is a substantial proportion of partnership leaders who believe their organizational model may need to evolve to a more structured form.

7. Partnership leadership style tends to evolve toward servant leadership.

While all of the partnerships have a "director" with a team that is responsible for the day-to-day operations, the characteristics of the leaders appear to be changing. As discussed earlier, in many instances charismatic leaders were instrumental in conceiving and creating the partnership. They were committed to addressing a community health issue about which they were passionate and they provided inspirational leadership.

As turnover occurs in the partnerships' leadership positions, it appears that persons with the capacity to achieve progress through influence and consensus-building skills are required and are being selected for leadership roles. In the coalition models that are prevalent among these partnerships, the partnership directors have substantial responsibility and accountability, but limited decision-making authority and staff resources. Moreover, most of the partnerships are heavily dependent on volunteers who need support and encouragement to maintain enthusiasm and engagement.

As a result, what appears to be emerging is a pattern of identifying and appointing partnership directors and key staff members who possess and demonstrate many characteristics of a management style known as "servant leadership." In the words of Larry Spears:

> "…we are beginning to see that traditional, autocratic, and hierarchical modes of leadership are yielding to a newer model — one based on teamwork and community, one that seeks to involve others in decision making, one strongly based in ethical and caring behavior, and one that is attempting to enhance the personal growth of workers while improving the caring and quality of our many institutions. This emerging approach to leadership and service is called "servant-leadership."[46]

8. Financial sustainability remains a significant issue for many partnerships.

All of the partnerships in this study population have generated substantial engagement by many community organizations and groups and have demonstrated considerable success. However, with few exceptions, they were created without long-term sources of financial support, are lightly funded, and must constantly seek external grant support to maintain or enhance their programs and staff. Depending on grants from private and governmental sources does not facilitate efforts by partnership leaders to chart *long-term* plans and strategies and solidify staff resources that are needed to execute them. At this point in their history, several of these successful partnerships depend largely upon a single grant program to support and sustain their existence. If, for whatever reason, that source of support is not renewed and an equivalent source is not secured, the partnership's future is in jeopardy.

It seems clear that having one or more strong "anchor institutions" whose leadership is truly committed to the partnership's mission and is willing to incorporate substantial financial support into their basic budget structure *and/or* securing another reliable source of on-going financial support is critical to the long-term survival of these partnerships. In addition to anchor institutions such as hospitals, health systems, and strong public health departments, other long-term sources of financial support could include health plans whose leaders understand the need to focus more resources on population health, local employers who grasp the value partnerships of this nature can provide for their community, and local government. Obviously, sustained financial support from any of these sources is dependent on the partnership's ability to demonstrate *evidence-based impact on improving community health* using measures and metrics that are clear and compelling to decision-makers and the community at large.

9. Many partnerships are challenged to demonstrate measurable progress in actually improving the health of the communities they serve.

A basic goal of all 12 partnerships is to demonstrate that their programs and services will have a positive impact on the health of the communities they serve. However, in all cases, the partnership leaders have learned how difficult it is to show solid evidence of sustained improvement, particularly on overall mortality and morbidity measures.

With respect to measuring and documenting impact, three patterns are clear: First, partnerships that have a specific focus (e.g., the Detroit Regional Infant Mortality Reduction Task Force) can more readily achieve and demonstrate positive impact than partnerships with a more expansive mission such as "becoming one of America's healthiest communities." Clearly partnerships that have a comprehensive mission are called to institute or facilitate a larger set of interventions and make impact on broader sets of health measures, with implications for resources, effort, and time. Second, most of the partnerships' leadership teams (11 of the 12) have adopted objectives for improving the health of their communities, strategies to achieve them, and metrics to employ in measuring and assessing progress. Many have embraced *short-term* measures focused on program development, participation in partnership activities, and process measures in order to demonstrate mission-related progress and, thereby, sustain community interest and support and maintain momentum.

Finally, *all* of the leadership teams understand that a matrix of factors — access to medical services and demographic, environmental, genetic, lifestyle, prevention services, and socioeconomic factors — combine to determine the health of a population group. Their experience in striving to address the partnership's particular mission — whether it is narrowly-focused or more expansive — has acquainted them with the importance of logic models that recognize this complexity and depict the linkages between these basic determinants and *intermediate* objectives and outcomes which, if achieved, can produce improvements in *overall* measures of their community's health.

Among the leaders of these successful partnerships, there is growing understanding that the existing body of science about these linkages is imperfect and they have great interest in both basic and applied research that would provide them useful information, insights, and guidance.

Selected Features

The partnerships in this study population, while all successful, are diverse in several respects including their focus, organizational model, and the size and location of the community they serve. Through the multi-step process of selecting these partnerships for in-depth study and during site visits, it became clear to the research team that all of them are distinctive in many ways and that all have unique features.

This realization prompted the following question to each partnership director: "Would you please identify and describe *one* feature of your partnership's structure, strategies, policies, or processes you and your team believe has proven, over time, to be *particularly* beneficial for the partnership and its operations?" All readily agreed to do so. Subsequently, guidelines with respect to length and format were provided and, during the summer of 2014, all of the partnership teams prepared descriptions of the partnership features they selected to showcase.

The research team greatly appreciates the support of the partnerships' directors and their teams in selecting and describing these features. All have proved to be valuable for their particular organizations; the partnership teams and our research team hope the readers of this report also will find them to be useful.

These features are presented in Appendix C. In alphabetical order by the state where they are located, they have been included in the following table.

Partnerships	Selected Feature
Kaiser Foundation Hospitals and Health Plan Oakland, California	"Community Health Initiatives: From Deep Roots to Creating Impact at Scale"
California Healthier Living Coalition Sacramento, California	"Key Elements of a Successful Collaboration in California"
St. Johns County Health Leadership Council St. Augustine, Florida	"St. Johns County Health Leadership Council"
Quad City Health Initiative Quad Cities, Iowa and Illinois	"Building a Governance Model to Support Regional Collaboration on Improving Community Health"
Fit NOLA Partnership New Orleans, Louisiana	"The Convener Role in Building Successful Collaboration"
HOMEtowns Partnership MaineHealth Portland, Maine	"A Winning Combination: Vision and Sustainability"
Healthy Montgomery Rockville, Maryland	"The Triumvirate of Champions"
Detroit Regional Infant Mortality Reduction Task Force Detroit, Michigan	"Competing Health Systems Collaborate to Transform Communities for Women and Children"
Hearts Beat Back: The Heart of New Ulm Project New Ulm, Minnesota	"Leveraging Data to Mobilize a Community"
Healthy Monadnock 2020 Keene, New Hampshire	"Engagement Through Evaluation"
Healthy Cabarrus Kannapolis, North Carolina	"Collaborative Assessment and Action Planning Processes"
Transforming the Health of South Seattle and South King County Seattle, Washington	"Transforming Health in King County, Washington"

State-Level Initiatives to Promote Hospital –Public Health Collaboration in Improving Community Health

In the process of identifying successful partnerships involving hospitals, public health departments, and other stakeholders focused on improving the health of the communities they serve, the research team had the opportunity to learn about two *state-level* initiatives — in New York and in Maryland — intended to encourage and support such initiatives.

In New York, the State Health Commissioner and the State Public Health and Health Planning Council developed in 2008 the "New York State Prevention Agenda: 2008-2012," which outlined goals and strategies for assessing and improving the health of communities throughout this large and diverse state. The State Health Commissioner that year also issued a directive that called for hospitals and local health departments to *collaborate* in completing a community health assessment and identifying priorities they could jointly address.

In 2013, the Council and the Department developed the second cycle in this initiative known as "Prevention Agenda: 2013-2017." Local health departments were asked to work with their local hospital partners to conduct a collaborative assessment, identify at least two priorities from the State plan, and jointly develop a community health improvement plan.

A multi-disciplinary work group established by the State Public Health and Health Planning Council, called the "Ad Hoc Committee to Lead the Prevention Agenda," has served an important role in guiding these efforts and monitoring progress. The health assessments, accompanying community health improvement plans, and the impact of the directives to promote hospital–public health collaboration on population health are in the process of being evaluated. Based upon preliminary information available at this time including interviews with senior State Health Department officials, hospital executives, and other parties who are involved in these efforts, it would appear these directives have accelerated the development of on-going communications and cooperation between public health and hospital sectors in New York. It is expected that the Health Department will provide a formal report on their findings later in 2014.

In Maryland — a state with a long and unique history of hospital rate review and control — the State's Secretary of Health and Mental Hygiene initiated in 2011 a statewide program to assess the health of communities, identify and prioritize health needs, and promote collaborative efforts involving hospitals, local health departments, and other parties. As in New York, state health officials worked closely with the state hospital association and local hospital leaders to seek their input and build understanding and support for this state-wide initiative. Outcomes to-date include the establishment of 20 "local health improvement coalitions" chaired by local health officials, and including representatives of hospitals in that district. The Maryland Community Health Resources Commission is providing some funding support for the local health improvement coalitions and, in several instances, the hospitals also are contributing financial resources and/or in-kind support. At the state level, substantial investments are being made in compiling existing information about state-level and district-level health status, the factors that affect population health, intermediate and overall population health measures, and related metrics. This information is being made available to local health officials, hospitals, and the public at large, and state officials are committed to continuous improvement in its content and format.

These efforts clearly are consistent with the IRS provisions resulting from ACA that call for collaboration between hospitals, public health agencies, and other parties in assessing community health needs, setting priorities, and developing strategies of addressing them. It is too early to objectively assess the impact of Maryland's initiatives or the success of the local health improvement coalitions. However, the Secretary of Health and Mental Hygiene and his team are pleased by the response to-date by local health officials, the hospital community, and the Maryland Health Resources Commission and are committed to on-going evaluation *and* improvement in state-wide strategies, methods, and practices.

State-level initiatives intended to promote collaboration by hospitals, public health agencies, and other parties to assess and improve community health are underway or are being planned in states in addition to New York and Maryland.[47] Identifying and examining them are beyond the scope of this study. However, assessing the design, impact, and success of the New York and Maryland initiatives and those that are found to exist in other states could be fruitful and beneficial for all parties.

Section IV. Conclusions, Recommendations, and Closing Remarks

As stated in Section I, the overall purpose of this study is to identify and examine successful partnerships involving hospitals, public health departments, and other stakeholders who share commitment to improving the health of communities they serve and ascertain key lessons learned from their collective experience. The study's objectives are to:

- Locate collaborative partnerships including hospitals and public health departments that are focused on improving community health;
- Identify a set of these partnerships that have been in operation for at least two years, have demonstrated successful performance, and are diverse in location, form, and focus;
- Examine these partnerships to gain knowledge about their genesis, their organizational arrangements, their goals and how progress is assessed, and the lessons learned from their collective experience; and
- Produce information and insights that will assist leaders of public and private organizations and policy makers in building strong, successful partnerships designed to improve community health.

Studies by the Commonwealth Fund, the Institute of Medicine, and other organizations have demonstrated that, for many years, the USA has expended a larger share of our nation's resources on health care than other developed countries, but the outcomes in terms of access to services, the quality of those services, and the health of our population do no match other countries whose spending per capita is lower.[1, 2] As a result of mounting evidence, growing concerns of public and private purchasers of health services, and more media attention, there is increasing awareness in *all* sectors of our society about the need for transformational change.

It has become clear that restraining the increase in health expenditures and, at the same time, improving the health of families, communities, and society at large demands *broader* approaches that address the full array of factors affecting health status. Improving access to outpatient and inpatient medical services and the quality of those services — while important and necessary — are insufficient strategies for resolving the vexing health challenges our nation faces. Greater attention and resources must be devoted to addressing the basic determinants of health; promoting a safer environment and healthier lifestyles; preventing illnesses and injuries; early detection and treatment of health problems; and building a "culture of health"[20] in communities across the country.

There also is growing recognition that designing, implementing, and sustaining more comprehensive approaches to promoting the overall health of communities and population groups will require higher levels of mutual understanding, communication, and collaboration among health delivery organizations and the public health sector than prevailed in the past.

This study has examined a set of 12 partnerships comprised of hospitals, public health departments, and other community organizations working together to improve the health of the communities they serve. We believe these partnerships — while diverse in their specific form, focus, and location — are proving to be important vehicles for identifying and addressing community health needs. In addition, all of these partnerships have reached out and engaged a *wide* range of local organizations, groups, and citizens in their mission of improving community health. Collectively, these 12 partnerships have involved hundreds of public and private organizations and thousands of community volunteers. In doing so, they have successfully informed broad cross-sections of their communities

about the determinants of health, health issues in their communities that need to be addressed and how that can be done, and the long-term value of improving the overall health of their communities. Through engaging community organizations and citizens in their programs and activities, these partnerships are generating collective interest and action, building community spirit and social capital, and helping to create a "culture of health" within the communities they serve.

Enhancing the quality and experience of patient care, reducing per capita health care expenditures, and improving the health of our nation's population — the "Triple Aim" advocated by Dr. Donald Berwick and others — represent vitally important priorities for the USA. Addressing them effectively will require sustained commitment at the national, state, and local level, re-alignment of health-related expenditures and investments, and effective multi-sector collaboration. Based on previous work by other organizations and findings from this study, our team has concluded that partnerships involving hospitals and/or health systems, public health departments, and other stakeholders who share commitment to collaborate in improving the health of the particular community they serve have an important social role and can serve as effective vehicles for collective action focused on population health improvement. However, this is very difficult work, and there are substantial challenges involved in organizing and operating partnerships. Based on empirical findings and our judgment, the team has formulated the following eleven recommendations:

Recommendation #1: To have enduring impact, partnerships focused on improving community health should include hospitals and public health departments as core partners but, over time, engage a broad range of other parties from the private and public sectors.

Comments: Assessing community health needs, setting priorities, developing objectives and metrics, building community support, and generating resources is challenging and complex. It has become clear that hospitals and public health departments are logical and essential partners in efforts to improve the health of the community they jointly serve. They should be among the *principal* partners in *all* partnerships focused on this social mission.

The IRS requirements for tax-exempt hospitals to conduct community health needs assessment and develop implementation strategies with input from public health agencies and other stakeholders and Public Health Accreditation Board standards calling for multi-sector collaboration in health needs assessment and health improvement planning are helping to build *hospital–public health* cooperation. Public health departments can serve as neutral conveners for these efforts, and hospitals that compete in other ways can find common ground to collaborate in this important work. *Inter-hospital* cooperation is occurring today in *many* of the partnerships included in this study.

However, to have sustained impact, partnership leaders should reach out and engage a broad range of *other* community organizations and groups in the partnership's mission and programs. School systems, colleges and universities, health plans, the business community, and local government[48] are among the parties who have a natural commonality of interest with partnerships devoted to improving the health of their community. Either as formal partners or through other forms of support, the active involvement of key community organizations such as these is a critical ingredient in the long-term survival and success of these partnerships. Generating collective action focused on community health improvement, building a "culture of health," and sustaining that culture over time requires broad-based, multi-sector understanding, engagement, and support.

Recommendation #2: Whenever possible, partnerships should be built on a foundation of pre-existing, trust-based relationships among some, if not all, of the principal founding partners. Other partners can and should be added as the organization becomes operational, but building and maintaining trust among all members is essential.

Comments: In building successful partnerships, careful consideration must be given to the characteristics outlined in **Appendix A**. *All* are important, but there is abundant evidence that a strong, trust-based relationship among principal partners is a *key* to effective operations. Lack of trust is a primary cause of partnership failures.[22] Pre-existing relationships among principal partners must be preserved and nurtured as the partnership moves beyond the planning and organizational phases into operations. Careful attention to on-going assessment of progress in relation to the partnership's goals and maintaining excellent communications among the partners is essential.

As consideration is given to adding *new* partners, it is imperative to assess the extent to which the core values and culture of the potential partner are congruent with those of the partnership. If there is *not* a good basis to believe they are compatible, adding a new organization or group as a partner involves risk. It is not necessary or feasible for independent organizations that establish or join a new partnership have identical values or cultures, but without a substantial level of congruence, problems are likely to occur. For long-term success, *all* partnerships require sustained attention on building and maintaining relationships among the principal partners that are based on honesty, mutual respect, and trust.

Recommendation #3: In the context of their particular community's health needs, the capabilities of existing community organizations, and resource constraints, the parties who decide to establish a new partnership devoted to improving community health should adopt a statement of mission and goals that focuses on clearly-defined, high priority needs and will inspire community-wide interest, engagement, and support.

Comments: Its mission statement and basic goals in support of that mission provide the foundation for every organization, regardless of its size. This certainly is true for multi-sector partnerships focused on addressing and improving community health. In every community in the USA, there are important health needs that require greater attention and more resources than existing institutions and agencies can provide. *If* they are well-designed and well-organized, partnerships involving multiple stakeholders can serve as catalysts for collective action in addressing unmet community health needs.

However, to be effective, the partnership's mission and goals must be defined strategically and pragmatically. The selection process must consider and balance many factors including prioritization of community needs, existing programs and services focused on them, current and potential sources of funding, and the pros and cons of using a collaborative partnership as a vehicle vis-à-vis other organizational models. *If* this process results in a decision to form a new partnership, it is imperative to carefully define the *scope* and *nature* of the partnership's mission and goals. A partnership with a mission that is unrealistically broad and complex is likely to experience difficulty in demonstrating sufficient progress to generate sustainable funding and maintain community interest. The mission and goals of successful organizations can be *expanded* as successful, evidence-based experience is demonstrated and additional resources become available; it is very difficult to shrink an organizational mission, contract its goals and programs, and, at the same time, maintain momentum and community support.

Recommendation #4: For long-term success, partnerships need to have one or more "anchor institutions" with dedication to the partnership's mission and strong commitment to provide on-going financial support for it.

Comments: While partnerships focused on improving the health of the community they serve are likely to be established by a small number of organizations that share common interests and mutual trust, the partnerships ordinarily will need to enlist additional partners and build multi-sector participation in order to survive and have substantial impact. It's also clear that the long-term survival and success of these partnerships is enhanced when one or more of the principal partners step forward to serve as a strong "anchor institution." Partnerships without one or more anchor institutions to provide a solid, dependable foundation of economic and non-economic support are inherently fragile and constantly dependent upon obtaining new sources of financial support to sustain core operations.

For many reasons, partnership leaders should put high priority on expanding the initial set of principal partners with additional partners from the private and public sectors of their community. These new partners should be expected to make substantive financial and/or in-kind support. However, the durability of these partnerships and the confidence and continuity of partnership staff is enhanced significantly by the presence and public commitment of strong, respected anchor institutions such as a local hospital, health department, a major employer, or another local organization that has embraced community health improvement as an integral part of its social responsibility and financial plans.

Recommendation #5: Partnerships focused on improving community health should have a designated body with a clearly-defined charter that is empowered by the principal partners to set policy and provide strategic leadership for the partnership.

Comments: Many partnerships, both in the private and public sectors, begin with informal cooperation involving a few organizations and/or groups who discover they have common interests and find informal ways to cooperate. If those efforts continue and trust-based relationships develop, they may evolve into closer and more formal collaborative partnerships structured through an affiliation agreement, a contractual arrangement, a memorandum of understanding (MOU), or other means. As informal cooperation develops into more formal partnerships that serve as vehicles for addressing complex community issues and involve substantial resources, it is prudent for the principal partners to create a mechanism for shaping the partnership's operating policies, providing strategic leadership, and making budgetary and resource allocation decisions within boundaries established by the principal partners. Many different titles can be used for these bodies; e.g., partnership board, steering committee, leadership council, etc. Whatever term is chosen, it is important for the role of this body to be defined by the principal partners, captured in a written "charter," and reviewed and updated on a regular basis.

For partnerships focused on improving community health such as those included in this study, these charters do not need to be complex or lengthy. However, they should at least state clearly (a) the partnership's mission and goals, (b) the new policy-setting body's composition, responsibilities, and authority, and (c) the powers and decisions that will be reserved to the principal partners.

Recommendation #6: Partnership leaders should strive to build a clear, mutual understanding of "population health" concepts, definitions, and principles among the partners, participants, and, in so far as possible, the community at large.

Comments: While growing attention is being given to "population health" in all sectors, there is not broad understanding and accord — even among health professionals — regarding definitions, priorities, or the metrics that should be used in assessing community health and measuring progress in improving it.[49] To assist in building a cohesive partnership and facilitate development of the partnership's objectives and metrics for assessing progress, it is beneficial for partnership leaders to intentionally devote efforts to building a solid base of common understanding among key stakeholders regarding important population health concepts, definitions, and principles. This should include on-going efforts to build knowledge and awareness within the community at large. A well-informed public is an important component in creating a community-wide "culture of health."

These efforts need to be deliberate and continuous, not an occasional event. Devoting time and effort to inform and educate partnership participants and the public at large is an *investment* that will pay long-term dividends for the partnership and the community it serves.

Recommendation #7: To enable objective, evidence-based evaluation of a partnership's progress in achieving its mission and goals and 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 monitor progress.

Comments: A partnership's mission and goals will drive the community health measures it should address. Selecting the specific objectives and targets they want to achieve and the most appropriate metrics to employ in monitoring the partnership's progress are among the leadership team's most important and challenging duties. However, unless these selections are based on the best science currently available, it is difficult — if not impossible — to evaluate the success of the partnership's strategies and programs *and* to be properly accountable to principal partners, other parties who provide financial and/or in-kind support, and the community at large. In the selection process, partnership leaders can benefit from obtaining expert advice and assistance from independent sources such as universities and professional associations.

All partnerships focused on community health improvement periodically should review and reassess their current objectives, targets, and metrics for evaluating progress toward their mission and goals. The existing science and tools in this realm, while imperfect, are evolving and improving. By demonstrating commitment to continuous improvement in their evaluation protocols *and* providing clear, understandable reports on progress in relation to their mission and goals, partnerships will gain credibility and earn the respect of key stakeholders and the community at large.

Recommendation #8: All partnerships focused on improving community health should place priority on developing and disseminating "impact statements" that present an evidence-based picture of the effects the partnership's efforts are having in relation to the direct and indirect costs it is incurring.

Comments: The intent of developing and regularly updating an "impact statement" of this type is to provide principal partners, current and potential funders, the community at large, and other key stakeholders with an objective "value proposition" that demonstrates the benefits the partnership is providing to the community in relation to its operating and capital costs. Some

partnerships already have developed or are in the process of developing "impact statements" of this nature; others have not. It is clear that making demonstrable improvement on key measures of community health is difficult and, in most instances, requires the investment of substantial time, efforts, and resources. This reality needs to be communicated clearly and understood by key stakeholders. Stakeholders deserve straightforward reports on the results these partnerships are achieving in relation to the investments that are being made in them. In many cases, the "impact statements" will demonstrate significant progress, make a compelling case for more investment, and inspire community-wide interest and support. If positive impact cannot be shown, partnership leaders need to explain why and "make the case" for further investment and support.

Recommendation #9: To enhance sustainability, all partnerships focused on community health improvement should develop a deliberate strategy for broadening and diversifying their sources of funding support.

Comments: This study has identified partnerships with "anchor institutions" — that is, hospitals, health systems or health departments who have made a *long-term commitment* to provide financial and in-kind support for the partnership. Partnerships with anchor institutions have a stronger and more durable foundation than those which do not. As a fundamental strategy for sustainability, existing partnerships focused on community health improvement and those that are formed in the future should strive to have one or more organizational partners make a commitment to serve as an anchor institution.

Very few partnerships included in this study have *local businesses* as principal partners and — other than Kaiser Foundation Hospitals and Health Plan, which is the anchor institution for Kaiser's National Community Health Initiatives — none at present have *health plans* serving as principal partners or providing substantial financial support.

Both local employers *and* health plans that provide coverage for population groups served by successful partnerships focused on community health improvement will benefit from the partnership's efforts. It is time, we believe, for successful partnerships to "make the case" both to major local employers and to health plans for more robust economic and non-economic support. Well-documented, evidence-based "impact" statements are likely to be essential in securing their interest, understanding, and support. These statements also will be helpful in obtaining and maintaining grant funding from federal and state programs, foundations, and private donors. An intentional strategy of expanding and diversifying a partnership's sources of funding will provide a stronger, more resilient financial foundation and enable the partnership's programs to be improved.

Recommendation #10: If they have not already done so, the governing boards of nonprofit hospitals and health systems and the boards of local health departments should establish standing committees with oversight responsibility for their organization's engagement in examining community health needs, establishing priorities, and developing strategies for addressing them, including multi-sector collaboration focused on community health improvement.

Comments: The idea of building closer and more durable linkages between hospitals and public health departments focused on improving the health of the communities they serve has important implications for traditional management and governance practices. Stakeholders expect and deserve assurance that both hospitals *and* public health departments are focused on addressing high-priority community health needs, fulfilling their respective social roles effectively and efficiently, and collaborating where those roles intersect.

Assessing community health needs, setting priorities, and taking measured actions to improve the overall health of the population they jointly serve is at the *heart* of this intersection. For nonprofit hospitals, providing community benefit is necessary to maintain tax-exempt status; making measurable contributions to improve the health of the population they serve surely is one of the most important ways hospitals can meet that requirement. Public health departments across the country have various forms of *statutory* responsibility to address and improve the health of the population they serve. In most jurisdictions, public health departments are the only governmental agency with statutory authority and accountability for community health.

If they have not already done so, it is time for board leaders and executives in nonprofit hospitals, health systems, and public health departments to establish standing board committees and charge them with oversight responsibility for their respective organization's role, priorities, and performance in the realm of population health improvement, including their strategies for promoting collaboration with other community organizations. The existence of standing board committees composed of persons with special interest and expertise in population health will focus board attention on important issues and galvanize on-going action and evaluation of progress.

Recommendation #11: If they have not already done so, local, state, and federal agencies with responsibilities related to population health improvement and hospital and public health associations should adopt policy positions that promote the development of collaborative partnerships involving hospitals, public health departments, and other stakeholders focused on assessing and improving the health of the communities they serve.

Comments: This study found that formal partnerships including hospitals, public health departments, and stakeholders from other sectors can be effective vehicles for addressing community health needs. In doing so, they can inform and engage individuals and groups throughout the community, inspire collective action, and contribute toward building a culture of health. We were able to identify 157 public–private partnerships in 44 states and examined 12 that clearly are being successful in addressing important health needs in their communities.

It is our belief that the public interest and well-being would be served by the establishment of more collaborative partnerships such as these in communities across the country. We further believe the development of these partnerships should be encouraged and supported by governmental agencies at the local, state, and federal level that, in various ways, have responsibility for helping to improve the health of American communities. Their encouragement and support can and should take many forms; e.g., active engagement and, when possible, financial contributions by local government; state-level policy positions and initiatives in support of hospital-public health collaboration such as now exist in Maryland and New York; and federal-level policies and programs that stimulate and support the development, implementation, and operations of *successful* hospital–public health partnerships.

In the private sector, the encouragement and support of hospital and public health associations at the state and national levels is very important. Organizations such as the American Hospital Association, the Association of State and Territorial Health Officials, and the National Association of County and City Health Officials already are providing leadership in promoting hospital-public health cooperation and encouraging the development of collaborative partnerships. There is great opportunity for these and other national and state associations to provide *multiple* forms of policy support, educational programming, and technical advice and assistance, both for existing partnerships and for communities who wish to consider developing new ones.

Closing Remarks

This study has examined highly successful multi-sector partnerships. The findings provide the basis for a set of recommendations intended to assist hospital, public health, and other community leaders as well as policy makers in developing strong partnerships devoted to improving community health.

The scope of this study and the methods we employed have limitations, and there are needs and opportunities for further studies regarding multi-sector partnerships focused on community health improvement. For example, a longitudinal study of how the 12 partnerships included in this study evolve in response to future changes in their communities, the health field, and society as a whole could provide useful insights about their creativity, flexibility, and sustainability. Will these partnerships be able to attract and maintain "anchor institutions" *and* generate greater levels of support from the business sector and from health plans that provide insurance coverage in their communities?

In the policy realm, what actions will be taken by local, state, and federal government and by state and national associations to foster the development of multi-sector partnerships focused on community health? Will there be growth in the development of new partnerships such as these in communities across the country? Health systems include a large and growing proportion of America's hospitals. If more of these systems would adopt a policy position in support of multi-sector collaboration focused on community health improvement, it is likely the formation of new partnerships would accelerate markedly.

Conducting this study has been an inspiring experience for our research team. These partnerships and their leadership teams have confronted many challenges — economic and non-economic — and more lie ahead. However, by engaging a broad range of community organizations and citizens, they are raising awareness, generating collective action focused on community health, and helping to build a "culture of health" in their respective communities. Clearly, in most instances the scope and scale of these partnerships are limited. To increase their impact, additional resources will be needed to scale-up current activities in their communities *and* spread their most effective features to *other* localities.

We believe a paradigm shift is occurring in America: there is growing realization that controlling the increase in health expenditures and improving the health of our nation's population will require major changes in traditional policies, practices, and organizational models. We view these partnerships as courageous pioneers and, we hope, as harbingers of a new era of innovation and multi-sector collaboration focused on building a robust culture of health in communities throughout America.

Section V. Acknowledgements

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My teammates and I wish to express appreciation to:

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Appendix A – Core Characteristics of Successful Partnerships

CORE CHARACTERISTICS AND RELATED INDICATORS OF SUCCESSFUL PARTNERSHIPS INVOLVING HOSPITALS, PUBLIC HEALTH DEPARTMENTS, AND OTHER PARTIES

Core Characteristics and Key Indicators

1. Vision, Mission, and Values – The partnership's vision, mission, and values are clearly stated, reflect a strong focus on improving community health, and are firmly supported by the partners

- Vision, mission, and values are set forth in a written document and shared with key stakeholders, including the community the partnership serves
- Partners are committed to support the partnership's vision, mission, and values
- A board, a steering committee, or other body has the responsibility and authority to adopt policies and approve initiatives that support the partnership's mission

2. Partners – The partners demonstrate a culture of collaboration with other parties, understand the challenges in forming and operating partnerships, and enjoy mutual respect and trust

- Partners have a tradition of participating in collaborative arrangements
- Partners share mutual respect and trust for one another
- Partners are open and transparent with one another
- Partners focus on developing programs in which they have expertise and/or can secure external talent readily and efficiently

3. Goals and Objectives – The goals and objectives of the partnership are clearly stated, widely communicated, and strongly supported by the partners and the partnership staff

- The partnership's goals, objectives, and programs are based on community needs with substantial community input
- The partnership's goals and objectives are set forth in a written document and shared with key stakeholders, including the community the partnership serves
- The goals and objectives include meaningful and measurable outcomes and a timeline for achievement
- Information regarding progress towards the partnership's goals and objectives is regularly provided to the partners, the community, and other key stakeholders

4. Organizational Structure – A durable structure is in place to carry out the mission and goals of the collaborative arrangement. This can take the form of a legal entity, affiliation agreement, memorandum of understanding, or other less formal arrangements such as community coalitions

- Organizational documents recite the key features of the partnership including its mission, goals, and core policies
- The partnership's board, or other body with governance responsibility, is comprised of persons with the capability needed to effectively provide direction, monitor progress, and adopt action plans as required to ensure continued progress
- Tax-exempt status is preferred but not required

5. Leadership – The partners jointly have designated highly qualified and dedicated persons to manage the partnership and its programs

- Leadership roles, responsibilities and decision-making authority are defined in writing, honored by key parties, and updated on a regular basis
- Members of the partnership's staff have mutual respect for each other, compatible values, and dedication to build and maintain a successful, trust-based partnership
- The partners and members of the partnership's staff share "ownership" of the partnership and demonstrate commitment to its long-term success

6. Partnership Operations – The partnership institutes programs and operates them effectively

- Partners identify resource requirements (human and financial), build capital and operating budgets that are sufficient, and successfully secure those resources
- Communication channels among the partners, staff, the community, and other stakeholders are clear, transparent, and effective
- Mechanisms to identify and resolve conflicts or issues are well-established and used proactively

7. Program Success and Sustainability – The partnership is operational and clearly has demonstrated successful performance

- The partnership has been in operation for at least two years
- The partnership assesses community health needs, prioritizes those needs, and develops evidence-based programs and strategies to address them
- There is solid evidence of community engagement and support
- There is solid evidence of successful operating performance, including clear potential to have long-term impact on community health

8. Performance Evaluation and Improvement – The partnership monitors and measures its performance periodically against agreed-upon goals, objectives, and metrics

- The partners and staff are deeply committed to ongoing evaluation and continuous improvement
- Measurable outcomes, metrics, and scorecards that enable evidence-based assessment of the partnership's performance are employed consistently
- The partnership's goals, objectives, and programs are assessed regularly; findings are reported to the governing body; and actions are taken to improve the partnership and its performance

Selected Sources of Information Used in Compiling the Characterisitcs and Related Indicators

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Appendix B - List of Nominated Partnerships

The study team collected information on the following partnerships between September and December 2013 to identify candidate partnerships for the study that include hospitals and health departments, and focus on improving community health. This was the first step in a process to identify partnerships that also met the baseline criteria of being operational for at least two years and demonstrating successful performance. To identify the potential study population of such partnerships, the research team (1) developed an electronic nomination form to collect substantial information about partnerships including their origin, mission, organization, and operations; (2) pre-tested the form with selected leaders in the hospital and public health communities; and (3) sought the assistance of national associations in announcing the study and inviting nominations. The associations' response was positive and, during September-November 2013, announcements of the study — including instructions and encouragement to nominate partnerships for the study — were distributed to their respective constituencies by AcademyHealth, the American Hospital Association, the American Medical Association, the Association of State and Territorial Health Officials (ASTHO), the ASTHO-Duke University Study Group, the Association for Community Health Improvement, the Catholic Health Association, the Centers for Disease Control and Prevention, the National Association of County and City Health Officials, several state and metropolitan hospital associations, and the Public Health Practice-Based Research Networks. In addition, the research team scanned current literature and contacted the ASTHO Primary Care and Public Health Integration project staff to identify partnerships that appeared to meet the baseline criteria and facilitated their nomination.

As of early December 2013 when the nomination process was curtailed, over 160 nominations were received. After review by the research team, 157 nominations included complete or nearly complete information, and warranted further assessment and consideration. These partnerships are located in 44 states, and are listed below. Further screening and assessment of the 157 nominated partnerships involved a multi-step process to identify the final candidates for on-site interviews and in-depth study; see the methodology section of this report for further details.

State	City	Partnership Name
Alaska	Anchorage	Healthy Alaskans 2020
Arizona	Phoenix	Arizona Community of Care Network
Arizona	Phoenix	Maricopa County's "Recovery Through Whole Health"
Arkansas	Little Rock	Hometown Health Improvement (HHI)
California	Irvine	St. Joseph Hoag Health
California	Monterey	Community Hospital of Monterey Peninsula–Community Benefit Program
California	Oakland	Kaiser Permanente's Corporate Community Health Initiatives for Healthy Eating and Active Living
California	Sacramento	California Healthier Living Coalition
California	Sacramento	California Maternal Health and Care improvement thru multi-stakeholder partnerships: Preconception Health Council of California
California	Sacramento	California Maternal Health Collaborative and Care Improvement Through Multi-Stakeholder Partnerships.
California	Sacramento	Hospital Breastfeeding Quality Improvement and Staff Training Project (BBC)
California	San Diego	San Diego County Childhood Obesity Initiative
California	San Francisco	San Francisco Hospital-Primary Care Collaborative for Quality Improvement
California	San Jose	RotaCare Free Clinic of Mountain View
California	Santa Maria	Kohl's Healthy for Life Wellness Program

Appendix B

State	City	Partnership Name
California	Santa Rosa	Community Activity and Nutrition Coalition of Sonoma County (CAN-C)
California	Whittier	Activate Whittier
Colorado	Pueblo	Pueblo Triple Aim Coalition
Connecticut	Hartford	Putting on AIRS: Asthma Indoor Reduction Strategies
Connecticut	Wallingford	Partnership to Create a CHNA Guide Template For Use Across the State and Country
Delaware	Wilmington	Delaware Promoting Health and Prevention
Florida	Fort Meyers	Healthy Lee Coalition
Florida	Jupiter	Jupiter Volunteer Clinic
Florida	Kissimmee	Osceola Health Leadership Council
Florida	Miramar Beach	Pediatric Navigator Program
Florida	Oviedo	Reduce Obesity in Central Florida Kids
Florida	St. Augustine	St. Johns County Health Leadership Council
Georgia	Atlanta	Atlanta Regional Collaborative for Health Improvement (ARCHI)
Georgia	Atlanta	Georgia Infant Mortality Project
Georgia	Atlanta	Health Promotion Action Coalition

State	City	Partnership Name
Georgia	Gainesville	Health Access Initiative & Good News Clinic
Georgia	Marietta	Cobb 2020 MAPP Implementation
Georgia	Savannah	Good Samaritan Clinic
Idaho	Boise	CARE Maternal/Child Health Clinic
Idaho	Boise	Implement Text4Baby Initiative
Illinois	Aurora	Kane County Community Health Assessment/Improvement Collaborative
Illinois	Chicago	Illinois Poison Center: Partners in Poison Prevention and Treatment
Illinois	Chicago	Illinois Stand Against Cancer: Breast and Cervical Cancer Screening in Chicago, IL
Illinois	Joliet	Will County MAPP Collaborative
Illinois	Princeton	Rural Illinois Stroke Care and Awareness
Illinois	Waukegan	Be Well Lake County
Indiana	Indianapolis	Indiana Health Department & Hospital Assn Collaboration, Indiana Indicators Data website
Indiana	Indianapolis	Indiana Hospital Association Coalition for Care
Indiana	Indianapolis	Indiana Immunization Portal: MyVax Indiana
Iowa	Davenport	Quad City Health Initiative

Appendix B

State	City	Partnership Name
Iowa	Des Moines	Better Choices/Better Health Stakeholder Steering Committee
Iowa	Onawa	Monona County Community Alliance
Kansas	Topeka	Immunize Kansas Kids
Kansas	Topeka	Kansas Health Matters: A Partnership to Improve Community Health
Kentucky	Ashland	Healthy Choices Kentucky
Kentucky	Bowling Green	Barren River Community Health Planning Council
Kentucky	Campbellsville	Taylor County Wellness Coalition
Kentucky	Danville	The Hope Clinic and Pharmacy
Kentucky	Frankfort	Franklin County MAPP
Kentucky	Frankfort	Kentucky ER SMART
Kentucky	Frankfort	Kentucky Long-term Care Collaborative
Kentucky	Lexington	Kentucky Cancer Consortium
Kentucky	Louisville	KIPDA Rural Diabetes Coalition (KRDC)
Kentucky	Martin	Floyd County Dental/Oral Health Coalition
Kentucky	Mayfield	Graves County Health Department

State	City	Partnership Name
Louisiana	Baton Rouge	Improving Care for HIV Patients to Improve Health Outcomes and Lower Long-Term Costs
Louisiana	New Orleans	Fit NOLA Partnership
Maine	Portland	HOMEtowns Partnership (Health Of ME (Maine) towns)
Maryland	Baltimore	Maryland State Health Improvement Process
Maryland	Bladensburg	Port Towns Community Health Partnership
Maryland	Elkton	Cecil County Community Health Advisory Committee
Maryland	Rockville	Healthy Montgomery
Massachusetts	Boston	Boston Children's Hospital Community Asthma Initiative
Massachusetts	Boston	Technology for Optimizing Population Care
Massachusetts	Revere	Revere CARES Coalition
Massachusetts	Somerville	Community and Clinical Preventive Linkages of Cambridge and Somerville
Massachusetts	Springfield	Coalition of Western MA Hospitals
Massachusetts	Worcester	UMass Memorial Prevention Partnerships
Michigan	Detroit	Detroit Regional Infant Mortality Reduction Task Force: Sew Up the Safety Net Project
Michigan	Grand Rapids	Alliance for Health

Appendix B

State	City	Partnership Name
Michigan	Grand Rapids	Spectrum Health Healthier Communities Department
Michigan	Muskegon	Mercy Health Community Health Needs Assessment; Coalition for a Drug Free Muskegon County
Michigan	Royal Oak	Beaumont Health Parenting Program
Minnesota	Minneapolis	Hennepin Health (ACO)
Minnesota	Minneapolis	Minnesota Community Measurement
Minnesota	New Ulm	Hearts Beat Back: The Heart of New Ulm Project
Minnesota	Rochester	Olmsted County Community Healthcare Access Collaborative
Mississippi	Jackson	Mississippi Trauma Care System
Missouri	Jefferson City	Missouri Time Critical Diagnosis System for Trauma, Stroke, and STEMI
Missouri	St. Joseph	Healthy Communities and emPowerU
Montana	Helena	Montana Cardiovascular Disease and Diabetes Telehealth Program
Montana	Helena	Montana Telestroke Program
Montana	Sidney	Richland Health Network - Richland County Community Diabetes Project
Nebraska	Kearney	Tri-Cities Medical Response System
Nevada	Carson City	Nevada Immunization Cocooning Program

State	City	Partnership Name
New Hampshire	Concord	Foundation for Healthy Communities
New Hampshire	Keene	Healthy Monadnock 2020
New Jersey	Trenton	New Jersey Baby-Friendly Hospital Initiative
New Jersey	Trenton	New Jersey Integration of Public Health Planning into Hospital “Community Benefit Planning”
New York	Albany	Healthy Capital District Initiative (HCDI)
New York	Albany	New York State Assessment, Feedback, Incentives, and eXchange (AFIX) Program
New York	Albany	New York State Prevention Agenda 2013-2017
New York	Albany	New York State Regional Asthma Coalitions and Asthma Outcomes Learning Network (AOLN)
New York	Albany	New York Tobacco Cessation Initiative
New York	Batavia	Genesee-Orleans-Wyoming Tri-County Partnership
New York	Brewster	Putnam County School Based Flu Vaccination Program
New York	Brewster	The Putnam County Live Healthy Putnam Coalition
New York	Canandaigua	Ontario County Health Collaborative
New York	Hauppauge	Long Island Health Collaborative
New York	Mayville	Chautauqua County CHA/CHIP

Appendix B

State	City	Partnership Name
New York	Rochester	Health Engagement and Action for Rochester's Transformation (HEART)
New York	Rochester	Monroe County Community Health Improvement Workgroup
New York	Schenectady	The Schenectady Coalition for a Healthy Community
New York	Syracuse	The Near Westside Initiative
New York	White Plains	Westchester Co Dept. of Health Planning with Hospitals
North Carolina	Asheville	Project Access
North Carolina	Asheville	WNC Healthy Impact
North Carolina	Carrboro	Community Health Assessment/Community Health Improvement Learning Collaborative
North Carolina	Charlotte	Mecklenburg Area Partnership for Primary-Care Research (MAPPR)
North Carolina	Durham	Northern Piedmont Community Care Network
North Carolina	Kannapolis	Healthy Cabarrus
North Carolina	Lexington	Davidson County Healthy Communities Coalition
North Dakota	Hazen	Sakakawea Medical Center (SMC)/Coal Country Community Health Center (CCCHC) Collaboration
North Dakota	Jamestown	Community Health Partnership
Ohio	Akron	Summit Partners for Accountable Care Community Transformation (Summit PACCT)

State	City	Partnership Name
Ohio	Toledo	Come to the Table
Ohio	Toledo	Fostering Healthy Communities
Ohio	Toledo	Lucas County Initiative to Improve Birth Outcomes
Ohio	Toledo	Toledo/Lucas County CareNet
Oregon	Portland	Healthy Columbia Willamette Collaborative
Oregon	Portland	Oregon Health Care Quality Corporation
Pennsylvania	Harrisburg	Pennsylvania Partnership Improves Health Access
South Carolina	Columbia	South Carolina's Perinatal Regionalized System of Care: Reducing Premature Births and Infant Mortality
South Carolina	Charleston	South Eastern African American Center of Excellence in the Elimination of Disparities in Diabetes
South Carolina	Spartanburg	The Road To Better Health
Tennessee	Memphis	Healthy Memphis Common Table
Tennessee	Memphis	Healthy Shelby
Texas	Austin	Texas Reduces Premature Births
Texas	Fort Worth	Cook Children's Homeless Initiative - Fort Worth
Texas	Fort Worth	Healthy Tarrant County Collaboration

Appendix B

State	City	Partnership Name
Texas	Lockhart	Healthy Coalition of Caldwell County
Utah	Salt Lake City	Utah Asthma Program
Utah	Salt Lake City	Utah's Regional Medical Surge Coalitions
Vermont	Burlington	Chittenden County Food & Nutrition Equity Project
Vermont	Williston	Vermont Health Systems and Clinical-Community Linkages
Virginia	Fishersville	Community Health Forum
Virginia	Manassas	LEAP Team: Cross Continuum Collaboration
Virginia	Winchester	Our Health, Inc.
Washington	Concord	Washington Vaccine Association
Washington	Olympia	Prescription Drug Overdose Prevention Initiatives
Washington	Seattle	Transforming the health of South Seattle and South King County
Washington	Seattle	Vax Northwest
Washington	Seattle	Washington State Drowning Prevention Network
Washington	Tacoma	Tacoma-Pierce County Health Department
Washington	Vancouver	Clark County Hospital-Acquired Infection Task Force

State	City	Partnership Name
West Virginia	Charleston	Kanawha Coalition for Community Health Improvement
Wisconsin	Chippewa Falls	Chippewa Health Improvement Partnership
Wisconsin	Racine	Greater Racine Collaborative for Healthy Birth Outcomes (GRC4HBO)
Wyoming	Cheyenne	Laramie County Community Partnership

Notes:

1. Three partnerships declined the invitation to be listed in this project report.
2. Study data were collected and managed using REDCap electronic data capture tools hosted at the University of Kentucky. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources.

   See: Paul A. Harris, Robert Taylor, Robert Thielke, Jonathon Payne, Nathaniel Gonzalez, Jose G. Conde, Research electronic data capture (REDCap) - A metadata-driven methodology and workflow process for providing translational research informatics support, *J Biomed Inform*. 2009 Apr;42(2):377-81, available at http://www.sciencedirect.com/science/article/pii/S1532046408001226

Appendix C – Selected Features of the Participating Partnerships

Kaiser Foundation Hospitals and Health Plan
Oakland, California

COMMUNITY HEALTH INITIATIVES: FROM DEEP ROOTS TO CREATING IMPACT AT SCALE

Partnership Profile

Model of Collaboration: Established in 2004, Kaiser Permanente's (KP) National Community Health Initiatives focus on a wide range of community health improvement efforts, including but not limited to place-based initiatives through the engagement of local collaboratives in more than 50 communities in KP's service area, each with its own organizational structure.

Mission and Focus: To improve the health of individuals, families, and communities by addressing the social, economic and environmental determinants of health by focusing on healthy eating, active living, community safety, economic stability and social and emotional health. We lift up the role of communities as vital settings that create the conditions of health as well as the importance of non-medical resources in communities that promote well-being and prevent disease.

Partnership Contacts:
- Dr. Loel Solomon, Vice-President, Community Health
- Pamela Schwartz, Director, Program Evaluation

The ten-year evolution of Kaiser Permanente's Community Health Initiatives — from a series of intensive, community-level efforts to what today represents a robust network of local, regional and national multi-sectoral partnerships — in many ways reflects the very essence of how Kaiser Permanente engages in the work of supporting healthy people and healthy places. Partnership, deeply rooted at the local level and effectively channeled to create a broader impact, is fundamental to Kaiser Permanente's efforts to improve population health. Moreover, what makes Community Health Initiatives so unique is the interplay between these partnerships at the local, regional and national level such that resources and learnings at every level are shared and integrated into the entire framework of public health advocacy and investment.

Kaiser Permanente's Community Health Initiatives began with the premise that human health is profoundly influenced by the places in which people live, work and play, and that multi-sectoral partnerships are required to make meaningful and sustained improvements in population health.

When these premises are applied locally at the community level, they translate into focused, place-based collaborative efforts that bring together public health departments and other local government agencies, schools, community groups and local leaders to identify the areas of greatest health need in a community and work jointly to address those needs. Community action plans set the agenda for focused improvements on the built environment, programs and policy changes. Examples include: increasing walkability through improvements to sidewalks and trails; promoting healthy eating through farmers markets, corner store conversions and school cafeteria upgrades; promoting worksite wellness policies and programs in local businesses; and using culturally tailored communications to promote healthy behavior and social norms change.

Along with financial support from Kaiser Permanente Community Benefit, local community health efforts also benefit from a variety of other Kaiser Permanente assets including the expertise and advocacy of Kaiser Permanente physicians, clinicians and health professionals; various forms of in-kind support and the engagement of the broader Kaiser Permanente workforce.

Complementing these local collaboratives is a network of regional and national partnerships that lift up community-driven priorities and help accelerate and sustain community changes. In 2007, a collaboration of funders — including Kaiser Permanente — created the Convergence Partnership to support and connect funders and health advocates working across multiple fields in order to spark innovation and spread a multi-disciplinary, equity-focused approach to creating healthy communities. The relationships built have resulted in partners working together to launch new groups and joint efforts, including The Partnership for a Healthier America, the National Collaborative on Childhood Obesity Research, Advancing the Movement, The Weight of the Nation and a number of state-based partnerships to improve access to healthy food and physical activity.

The impact of these partnerships has been substantial. They played a major role in the creation of the Prevention and Wellness fund as part of the Affordable Care Act; establishment of the federal Healthy Food Financing Initiative that brings healthier food into underserved communities; prioritization of walking, biking and public transit in federal transportation legislation and support for a shift in philanthropic focus for more than 80 state and local funders who have formed multi-sectoral convergence partnerships and innovation funds.

These partnerships create support for efforts to scale up local innovation, creating a "surround sound" of collective activity that builds momentum for the national healthy places agenda. The mutually reinforcing nature of local, state and national partnerships produces a synergy of positive change greater than the sum of its parts. Local efforts provide the insights, focus and evidence base to catalyze national efforts. National efforts provide the resources, funding, messaging and peer-to-peer know-how to support local efforts.

A rigorous and responsive cross-site evaluation is critical to the success of Community Health Initiatives. Evaluation focuses on measuring changes in community conditions as well as population-level behavior change and health outcomes. It emphasizes ongoing learning and program improvement which has led to important insights such as community-level "dose" — the combination of research and strength of complementary community-based interventions to affect population health — that have increased the impact of the work on the ground and contributed to the field. A series of case studies and peer-reviewed journal articles have documented significant improvements in healthy behaviors and health outcomes in Community Health Initiatives sites, particularly where communities have been able to implement "high dose" interventions.

What makes this all possible is the unique way in which Kaiser Permanente engages people and communities through multiple touchpoints — as a health care provider, a funder, a partner and a national advocate for multi-sectoral approaches to creating health places. These touchpoints have the ability to influence change on both a local, regional and national scale so that investments and public health interventions can be most effective in creating and sustaining healthy behavior change.

California Healthier Living Coalition
Sacramento, California

KEY ELEMENTS OF A SUCCESSFUL COLLABORATION IN CALIFORNIA

Partnership Profile

Model of Collaboration: Since 2006, the California Department of Aging (CDA), California Department of Public Health (CDPH), Dignity Health and Kaiser Permanente of Southern California have utilized a combination of Memoranda of Understanding (MOUs) and informal agreements to create a statewide partnership.

Mission and Focus: To expand the availability of evidence-based chronic disease self-management education (CDSME) programs proven to significantly help individuals across the state living with chronic disease.

Partnership Contact:
- Lora Connolly, Coalition Co-Chair

Several factors have been critical to the California Healthier Living Coalition's success. One essential element has been the strong leadership of the state departments (California Department of Aging, California Department of Public Health), the Technical Assistance Center (Partners in Care Foundation), and the major healthcare partners (Kaiser Permanente Southern California and Dignity Health) involved. Most of these core leaders have been engaged in this effort for twelve years. Their long working relationship has created a remarkable level of trust, collegiality, and shared passion for this work. They value the Coalition as a vital means of supporting and expanding access to proven evidence based chronic disease self-management programs throughout California.

The Coalition's purpose is very specific: to foster and expand access to a set of established evidence-based Chronic Disease Self-Management Education (CDSME) classes. Thus, the organization's members clearly understand and share this mission and purpose.

A second key element in the partnership's success lies in the Coalition's structure. Making these chronic disease programs widely available has required new alliances — bringing together public and private agencies and various business sectors that traditionally have not worked closely with each other. Success implicitly required the development of effective ways to:

- Create and maintain enthusiasm;
- Coordinate efforts;
- Leverage resources;
- Address challenges that arise;
- Identify and engage additional partnering networks to expand and sustain program access; and
- Share new resources and lessons learned as quickly as possible.

The Coalition was developed to be that vehicle. The Coalition structure involves bi-weekly leadership phone calls that include the state departments and technical assistance center staff to maintain contact, address administrative and programmatic issues, identify local resource needs, etc. Quarterly Coalition member meetings are held to provide program updates and opportunities for sharing challenges, new resources, and lessons learned. Topics are solicited from Coalition members and they also frequently present. The Technical Assistance Center is always available to assist members who have questions or challenges and also helps to link organizations needing training resources with individuals and/or agencies that could potentially assist in meeting those needs.

The Coalition's structure and its organizational culture have created a synergy among the partners that encourages leveraging all the resources available to support and expand these programs. In one community, for example, a local non-profit agency wanted to offer the Chronic Disease Self-Management Program workshop in Chinese, but needed some recently updated materials translated. They could not afford the translations, but did have a bilingual workshop leader. A healthcare partner in the Coalition paid for the translation, and it is now available to any organization that may need it via the Internet.

Through the Coalition, agencies that are just starting to offer these programs can identify other organizations in their vicinity who offer these programs so they can make cross-referrals (particularly for workshops offered in other languages) and coordinate when and where workshops are being offered. Making it possible for new workshop providers to connect with more experienced organizations can also help them achieve success more quickly.

Several organization members, particularly in the healthcare and housing sectors, have become strong program advocates within their own provider associations. This, in turn, has encouraged other organizations to become involved and has led to further statewide program expansion.

Several members of the California Healthier Living Coalition have developed their own county level coalition to provide this type of coordination and support to the diverse array of local organizations involved in these programs in their community. This statewide model of collaboration has been instrumental in bringing together a very diverse but clearly committed network of organizations dedicated to helping individuals with chronic health conditions improve their health and quality of life.

St. Johns County Health Leadership Council
St. Augustine, Florida

ST. JOHNS COUNTY HEALTH LEADERSHIP COUNCIL

Partnership Profile

Model of Collaboration: The St. Johns County Health Leadership Council is a voluntary collaborative which includes a variety of members from executive and staff positions of organizations throughout St. Johns County. The council is supported by staff from the Florida Department of Health in St. Johns County.

Mission and Focus: To promote, protect and improve the health of all people in St. Johns County, Florida. Focus areas include substance abuse, dental care, mental health, low birth weight infants and cancer issues.

Partnership Contact:
- Brenda Fenech-Soler, Council Co-Chair

Championed and facilitated by the local county health department, the Florida Department of Health in St. Johns County (DOH-St. Johns), the St. Johns County Health Leadership Council (HLC) is a collaborative of community partners dedicated to community health assessment and health improvement planning, whose mission is to promote, protect and improve the health of all people in St. Johns County, Florida.

Initially convened as a Task Force in 2005 by DOH-St. Johns, Flagler Hospital and County Health and Human Services to complete the county's first Community Health Assessment, in 2008 the Task Force was chartered as the St. Johns County Health Improvement Council.

Following publication of the county's second Health Assessment in 2008, attendance at Council meetings was dwindling, and although a core group of key stakeholders remained, it was clear there were opportunities for improvement. Assessment is a core function of public health, and recognizing their role in that capacity, DOH-St. Johns made a strategic and critical decision to facilitate the 2011 Community Health Assessment in-house, shaping the Council's direction in a major way, resulting in its finest partnership feature, a Council roster that includes both "decision-makers" and "boots-on-the-ground" members.

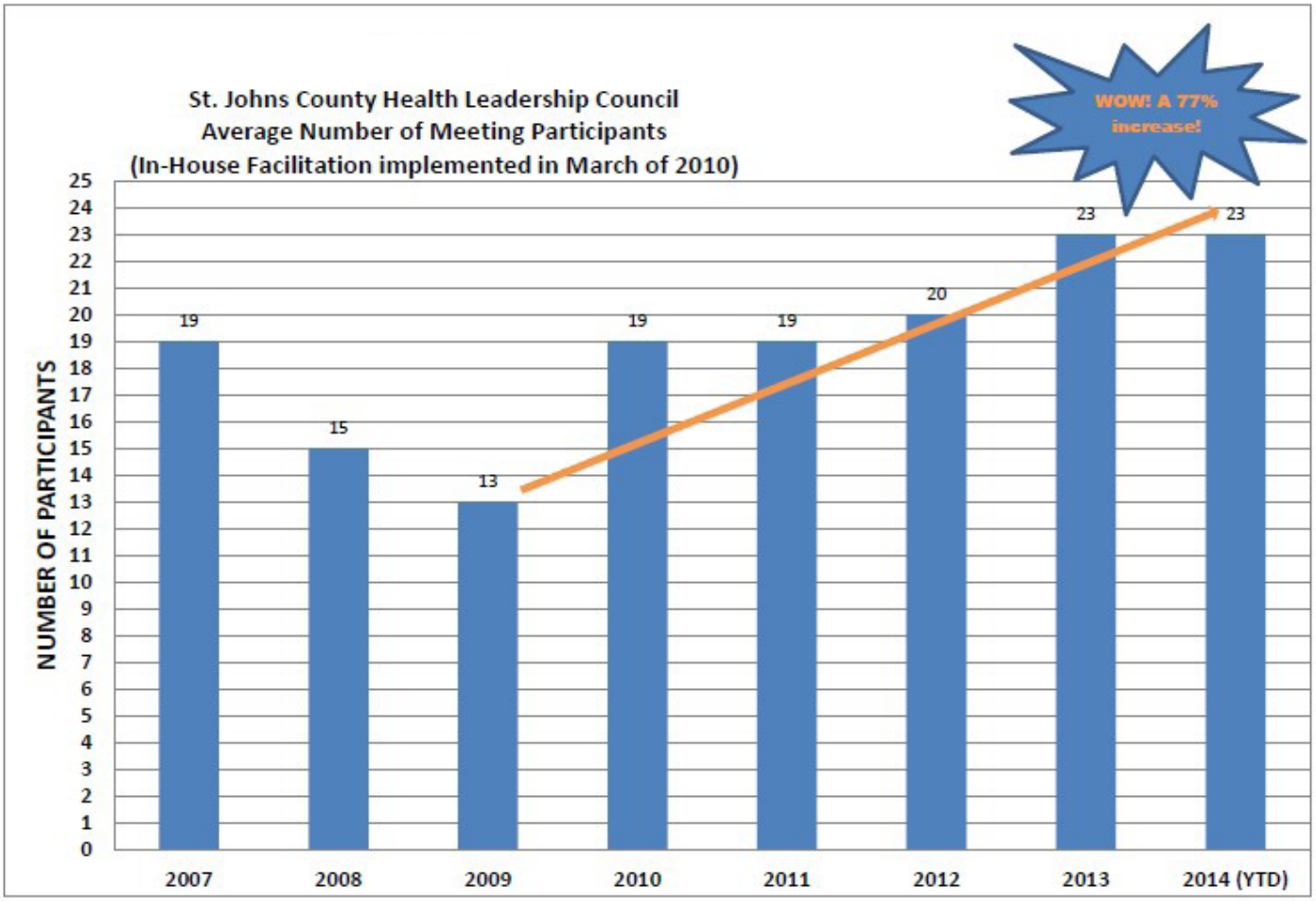
Community-wide strategic planning requires strong organization and a high level of commitment from the stakeholders who participate, and DOH-St. Johns determined a cycle of quality improvement was indicated to re-vitalize the Council. The Health Improvement Council was re-branded as the Health Leadership Council (HLC), and the roster was expanded to more fully represent both "decision-makers" and "boots-on-the-ground" members from key agencies. An action plan was developed that included a strategy to continue using the nationally recognized Mobilizing for Action through Planning and Partnerships (MAPP) process, but in a more systematic and methodical manner. DOH-St. Johns had successfully implemented a performance management model based on the Baldrige National Quality Program, and introduced evidence-based QA/QI techniques to the Council, augmenting the MAPP process. The Council now uses a Community Balanced Scorecard*, an effective tool to track and evaluate their strategic objectives. Additionally, planning, organization and meeting facilitation was enhanced to provide a better experience for Council members.

*Epstein, Simone and Wray, the Public Health Quality Improvement Handbook, (American Society for Quality, Quality Press, 2009).

68

Implementation of these strategies resulted in a 77% increase in the number of HLC meeting participants since 2009 (see Exhibit). The HLC has evolved into an effective collaborative and continues to build on past successes. The Wildflower Clinic is a shining example of this collaboration and community mobilization. What started as a preconception care outreach program and a need for dental services has blossomed into a medical and dental clinic that serves the medically uninsured, with sovereign immunity provided by the Florida Department of Health. Expansion of the local transportation system (Sunshine Bus), DOH-St. Johns' Public Health Mobile Centre and expanded Dental Clinic, and the new EPIC Treatment (Detox) Center are some other examples of the collective impact achieved by this partnership. Additionally, in 2014 for the third consecutive year, St. Johns County was ranked the healthiest county in Florida in the national County Health Rankings Report, which can be attributed not only to the work of the HLC, but also the entire St. Johns County public health system. The decision to facilitate the Council locally including a roster of decision-makers and boots-on-the-ground members and to employ a strategic planning process augmented with QA/QI tools is a replicable strategy, and it was pivotal for the HLC. Local leadership and effective facilitation have resulted in a Council that better understands and is more vested in the community they serve. They know and trust each other and work together effectively, using data to make evidence-based decisions to identify strategic issues, formulate SMART goals and develop strategies to drive community health improvement in St. Johns County.

Exhibit



Quad City Health Initiative
Quad Cities, Iowa and Illinois

BUILDING A GOVERNANCE MODEL TO SUPPORT REGIONAL COLLABORATION ON IMPROVING COMMUNITY HEALTH

Partnership Profile

Model of Collaboration: Quad City Health Initiative, formed in 1999, is a community coalition governed by a 25-member community board which includes representatives from local health departments, providers, social service agencies, educators, business and local governments.

Mission and Focus: To create a healthy community. Current focus is on issues of nutrition, physical activity & weight management; tobacco; mental health; and immunizations.

Partnership Contact:
- Nicole Carkner, Executive Director, QCHI

For the last 15 years, the Quad City Health Initiative (QCHI) has provided the planning and communications backbone to enable cross-sector community health improvement in the Quad Cities. Formed as a community collaborative in 1999, QCHI's mission "to create a healthy community" is rooted in a model of action that acknowledges the social determinants of health and the interrelationships between health status, health behaviors, access to care, education, employment, income, safety and the physical environment. With the financial support of its founding sponsors, Genesis Health System and UnityPoint Health-Trinity, and other partners, QCHI has built an infrastructure that harnesses the collective work of more than 120 volunteers from 60 organizations and has reached thousands of community members.

One of QCHI's most distinctive features is its regional approach to community health improvement, which has been a natural response to our community's unique geography. The Quad Cities is a metropolitan area with over 317,000 people living in the cities of Davenport and Bettendorf, Iowa, and Rock Island, East Moline and Moline, Illinois. Our community encompasses urban and rural areas in two counties across two states joined by the Mississippi River. This unique geography is also a source of great strength for our community, which has by necessity become expert at building bridges. Over a hundred and fifty years ago, building bridges was a literal challenge; the first railroad bridge to cross the Mississippi River was built to connect Davenport and Rock Island. In our modern era, however, we understand that virtual bridges across communities, economic sectors and population groups are the key to our continued success. The Quad Cities excels at developing cross-sector partnerships and building collective impact as a region.

Building collective impact on health starts for us with maintaining a governance model that supports regional collaboration. The QCHI is governed by a 25-member community Board which is responsible for guiding our strategy and organizational policies. The composition of this leadership group has been shaped by three primary considerations. The first consideration, given our regional focus on community health improvement, has been geographic inclusiveness. This has meant defining our Board positions to include parallel positions across our community; for example, simultaneously including the senior representatives from both county health departments and superintendents from local K-12 school districts in both Iowa and Illinois. We strive to maintain a balance of representatives from organizations located in each state while rotating individual representatives from smaller geographic units such as cities.

Our second consideration has been to create a Board that is representative of our community's economic and social sectors. In our early years, our Board was largely composed of representatives of the health and human services sectors whose work and interests aligned with QCHI's mission. Most recently, our Board structure has been influenced by the University of Wisconsin Population Health Institute's model for working across sectors. In 2011 we undertook a strategic restructuring of our Board after conducting focus groups with community leaders. It was clear that we could enhance our organizational effectiveness by expanding representation from business, government and education. We defined our Board to thus include representation from the business, healthcare, education, public health, government, community and philanthropic sectors. Given the central role of several organizations to our work, we structured 11 of our 25 Board seats to be *ex officio* positions for key community leaders. Two of these *ex officio* seats are reserved for the CEOs of Genesis Health System and UnityPoint Health-Trinity who also serve as permanent members of QCHI's Executive Committee. The personal engagement of the health systems' CEOs has been a critical success factor for QCHI, and their organizations provide significant in-kind support to the QCHI partnership. The remaining 14 Board positions are elected every two years with one possible term renewal. It is worth noting that this Board restructuring also reduced the overall size of our Board from 35 members to 25 members. Although perhaps still large by comparison to the average size of a non-profit Board, this size preserves our ability to be geographically inclusive of key positions in our community.

Our third consideration has been to recruit Board members with an attention to diversity at an individual level. Specifically, we've sought to achieve diversity in content knowledge, gender, age and race/ethnicity. Individual diversity contributes to more creative solutions as we work together to increase our community's health status and quality of life.

In order to support the operations of our 25-member community Board, we've created cascading levels of Committees and project teams that are coordinated by QCHI staff. Three standing committees of the Board provide oversight for our issue-based work (Project Committee), secure needed resources (Fundraising Committee) and guide administration and board development (Executive Committee). Issue-based project teams and coalitions, which include Board members and other community members, are developed as needed to address priority community health issues identified during our comprehensive, bi-state community health assessment process.

Our Board structure has created a solid foundation of leadership for community health improvement across geographic and organizational borders. Ensuring that we have all the key players represented in making strategic decisions translates directly into an enhanced ability to implement projects, policies, systems and environmental changes at a regional level.

Appendix C

Exhibit: QCHI Board Structure 2014

Board Member Seat Description	Sector	Number of Representatives
Ex Officio Members (11 seats)		
President & CEO, Genesis Health System	Healthcare	1
President and CEO, UnityPoint Health-Trinity	Healthcare	1
CEO, Quad Cities Chamber of Commerce	Business	1
Garrison Commander, US Army Garrison, Rock Island Arsenal (non-voting)	Government	1
Chair, Bi-State Policy Committee or Commission (an elected official)	Government	1
CEO, Community Health Care, Inc.	Healthcare	1
Public Health Administrator, Rock Island County Health Department	Public Health	1
Director, Scott County Health Department	Public Health	1
President, United Way of the Quad Cities Area	Philanthropy	1
CEO, Two Rivers YMCA or Scott County Family YMCA	Community	1
Executive Director, Bi-State Regional Commission	Government	1
Elected Members (14 seats)		
Board Member, Medical Society (a physician)	Healthcare	1
Education IA (K-12)	Education	1
Education IL (K-12)	Education	1
Higher Education	Education	1
City or County Administrator, IA or IL	Government	1
Business/Private Sector	Business	6
Community Leaders	Community	3

Fit NOLA Partnership
New Orleans, Louisiana

THE CONVENER ROLE IN BUILDING SUCCESSFUL COLLABORATION

Partnership Profile

Model of Collaboration: The Fit NOLA action blueprint, released in 2012, sets the course for the Fit NOLA partnership, a collective impact model which includes more than 200 organizations ranging from small neighborhood groups to Fortune 500 companies, with the City of New Orleans Health Department serving as the backbone support organization.

Mission and Focus: After becoming a *Let's Move!* city in 2011, Fit NOLA continues to move New Orleans toward becoming one of America's most fit cities by using policy, system and environmental change to create a community and culture that will enable nutritional and physical fitness.

Partnership Contacts:
- Charlotte Parent, RN, MCHM, Director of Health, City of New Orleans; Chair, Fit NOLA Partnership
- Katherine Cain, MPH, Manager of Strategic Performance and Partnerships

The finest feature of the Fit NOLA Partnership is the service it provides to partners as a convener. New Orleans is fortunate to have a wide range of stakeholders in the community who are concerned with promoting healthy lifestyles and reducing the incidence of obesity and chronic disease. This includes government agencies, non-profit organizations, universities, schools, businesses, entrepreneurs, foundations, faith-based groups, and health care organizations. Fit NOLA provides the venue for approximately 200 organizational partners from multiple sectors to come together to plan fitness and health events, create community resources, and increase awareness of opportunities for health and wellness. As the backbone organization of Fit NOLA, the City of New Orleans Health Department works to identify and invite potential partners to the table to ensure that the quality and diversity of participants remains high. Our main convening is our semi-annual partnership meeting. Our Spring Forum and Fall Forum are half-day meetings attended by over 100 participants. These meetings feature partnership updates, keynote speakers, panel presentations, breakout sessions, and networking opportunities for partners.

Fit NOLA provides the opportunity for more in-depth partner involvement through its six sector groups: Business, Health Care, School and Out-of-School, Community, Early Childhood, and Active Community Design. Sector groups meet quarterly and work on concrete projects. Sector groups are open to all who are interested and are typically comprised of like-minded professionals with common interests who yet might not ordinarily have the opportunity to work together. Each sector group has a voluntary chair or co-chair, which provides an opportunity for leadership to interested Fit NOLA partners.

The Fit NOLA Coordinating Group is the partnership's policy-setting body. Members of this group meet quarterly and come from a range of backgrounds including physicians, early childcare professionals, engineers, public health professionals, academicians, business people, and local and state government. Membership in the Coordinating Group provides another opportunity for local professionals to network and collaborate with each other to promote physical activity and healthy eating in New Orleans.

Fit NOLA also provides online opportunities that facilitate interaction and collaboration among its partners. It publishes a bi-weekly email newsletter that shares partner events and updates. Through its website it provides an online calendar of events with opportunities for physical activity and healthy eating promotion to which partners contribute. Fit NOLA also maintains active social media accounts through which partner updates and information are shared.

Using semi-annual partnership surveys following each Fit NOLA Forum, the Health Department receives feedback on how we're doing, what our partners need, how we can serve them better, and benefits they gain from being involved in the partnership. Sector group report-outs also demonstrate the effectiveness of collaboration. As the backbone organization, the City of New Orleans Health Department uses all of this information in combination with tracking a list of indicators reflecting short- and long-term outcomes, mostly available from public data sources, to gauge our progress towards becoming a more fit city. We utilize all feedback and performance tracking to improve how we work together and inform the overall direction of the partnership. We continue to develop and refine our performance metrics.

Fit NOLA partners report that coming together under the umbrella of Fit NOLA and taking advantage of Fit NOLA's opportunities for collaboration and networking are extremely energizing. Fit NOLA's role as a convener represents the important role that government can play to facilitate connections and introductions between those already doing great work in the community; to link partners to promote collaboration and coordination on projects; and to leverage expertise and funding in ways that enhance value and promote health.

HOMEtowns Partnership
Portland, Maine

A WINNING COMBINATION: VISION AND SUSTAINABILITY

Partnership Profile

Model of Collaboration: Established by MaineHealth through formal affiliation agreements with eight community hospitals, HOMEtowns Partnership began in 2012 as a means to grow capacity and increase responsibility for population health improvement. Through the US CDC's Community Transformation Grant: Small Communities Program (CTG), partnerships were expanded to include state government, regional public health districts and many other community partners.

Mission and Focus: To improve the health of the population in seven rural counties by increasing opportunities to prevent chronic disease through evidence-based interventions focused on weight, nutrition, physical activity and tobacco use. The project's *Learning and Dissemination Collaborative* strives to accelerate the spread of interventions through training, mentoring, evaluation and technical assistance.

Partnership Contact:
- Deborah Deatrick, MPH, Senior Vice-President for Community Health, MaineHealth

Like many hospitals and health systems in America, MainHealth's vision statement "working together so our communities are the healthiest in America" is intended to be aspirational and focuses on what *should be* healthcare's loftiest goal. To MaineHealth's Board of Trustees and senior leaders, the statement also serves as a kind of organizational GPS, connecting the system's core objectives (referred to in the industry as the Triple Aim, a conceptual framework devised by the Institute for Healthcare Improvement that links three important dimensions of health care – improved experience of care, reductions in per capita costs, and improved population health) to measurable improvements in individual and community health throughout the system's 11-county service area.

This vision has informed and governed our actions since the system was formed in 1997, and the 16-member Board of Trustees has reaffirmed their commitment to this core statement as new hospitals have joined the system and through the ups and downs of annual budget cycles. But vision, no matter how inspiring, means little without the resources needed for execution.

Recognizing that nonprofit hospital margins are often not substantial enough to yield the investments that are needed to improve population health, MaineHealth Board members and senior leaders developed a unique strategy to meet the challenge – to produce needed resources predictably and continuously that could help achieve the vision. The three-part strategy includes 1) partnerships with payers on projects of mutual importance, such as quality improvement; 2) aggressive pursuit of grants and contracts from public and private sources; and 3) modest annual allocations of the system's unrestricted net assets. Beginning in 2009 with an allocation of 0.2% of total unrestricted net assets, the allocation grew to 0.7% in 2014 and will, with Board approval, eventually expand to a full 1.0%.

It's the latter strategy that has been responsible for providing a bridge between resources produced through the other two strategies, while providing seed money for new, innovative ventures, such as expansion of a successful childhood obesity program called *Let's Go!* to the regions served by each MaineHealth member hospital. These funds are also used to expand clinical integration work, our patient centered medical home initiative, hospital-based tobacco treatment, and other population health

improvement activities that are implemented locally by member hospitals and system providers.
When system resources are paired with over $50 million in grants and contracts that have been secured from payer and other external sources, the result is a substantial, sustainable investment that allows continuous, sustained implementation and produces impressive outcomes. Progress is highlighted annually in another of the system's innovative initiatives – the MaineHealth *Health Index Report* (www.mainehealthindex.org), which tracks progress on the system's seven top population health priorities, such as childhood immunizations and preventable hospitalizations (see Exhibit).

MaineHealth's combination strategy has allowed the system to take advantage of episodic funding opportunities, such as the U.S. Centers for Disease Control and Prevention's (CDC's) Community Transformation Grant: Small Communities Program, which funded our HOMEtowns Partnership and in turn, supported chronic disease prevention interventions in seven counties through partnerships based at MaineHealth member and affiliate hospitals. We believe the system is moving steadily toward achieving our lofty vision of "working together so our communities are the healthiest in America."

Exhibit: MaineHeath's Seven Top Population Health Priorities

Increase childhood immunizations – *Increase the percent of 19-35 month olds up-to-date for a series of seven immunizations to 82% by 2016.*
Impact: State Immunization registry, new vaccine purchasing program, quality improvement Learning Collaborative, provider training, and novel parent education tools have contributed to an up-to-date rate of 73%, up from 69% in 2011.

Decrease tobacco use – *Decrease the percent of adults who smoke to 20% by 2016.*
Impact: Tobacco treatment specialists trained statewide, Breathe Easy Network recognized MaineHealth for achieving gold or platinum level smoke-free status among all member and affiliate hospitals, all MaineHealth hospitals implemented tobacco treatment services for patients (inpatient and ambulatory) and employees, and EMR expansion resulted in 500% increase in referrals to the Maine Tobacco Helpline.

Decrease obesity – *Decrease the percent of adults who are obese to 30% by 2016.*
Impact: Participation in *Let's Go!*, an evidence-based multisector childhood obesity prevention initiative expanded to all MaineHealth service area counties, resulted in improvements in physical activity and healthy eating-related behaviors, environments and policies, and all MaineHealth hospitals are participating in the national Hospital Healthy Food Initiative.

Decrease preventable hospitalizations – *Decrease the number of hospitalizations for ambulatory care-sensitive conditions per 1,000 Medicare enrollees to 58 or less by 2016.*
Impact: Provided care management for patients with diabetes to successfully reduce blood pressure, cholesterol, and control Hemoglobin A1c within the medical home, implemented protocols to improve care transitions to community providers and partners, and developed system-wide Advanced Directives strategy.

Decrease cardiovascular deaths – *Decrease cancer mortality rates based on 3-year averages of age-adjusted 1-year rates of deaths per 100,000 population to 202-208 by 2016.*
Impact: Trained 200+ clinicians in standard techniques to measure blood pressure, implemented Million Hearts campaign in primary care practice settings (aspirin, BP control, cholesterol, and smoking cessation) in collaboration with the Maine Centers for Disease Control and local public health partners.

Decrease cancer deaths – *Decrease cancer mortality rates based on 3-year averages of age-adjusted 1-year rates of deaths per 100,000 population to 200-205 by 2016.*
Impact: Increased colorectal cancer screening rates among patients and employees, provided low cost or free colonoscopies to underserved adults, developed system-wide oncology services plan, and increased referrals to the Maine Tobacco HelpLine for cessation counseling.

Decrease prescription drug abuse and addiction – *Decrease deaths due to drug overdose based on 3-year averages of age-adjusted 1-year rates of deaths per 100,000 population by 2016.* No target set yet.
Impact: Expanded use of the Maine Prescription Monitoring Program among physicians and hospitals; developed standard protocols for treatment of pregnant women on alcohol, opiates or other addictive substances; and implemented Drug Take Back Days with community partners.

Healthy Montgomery
Rockville, Maryland

THE TRIUMVIRATE OF CHAMPIONS

Partnership Profile

Model of Collaboration: A product of a community health needs assessment, Healthy Montgomery includes all five area hospitals, safety net clinics, minority health initiatives and social services agencies in a formal consortium of interested parties dedicated to health improvement.

Mission and Focus: To achieve optimal health and well-being for Montgomery County, Maryland residents focusing on access to health and social services, health equity, and enhancement of physical and social environments.

Partnership Contact:
- Dr. Uma Ahluwalia, Director, Montgomery County Department of Health and Human Services

The finest feature of Healthy Montgomery is the strong foundational support of the Montgomery County Department of Health and Human Services (MCDHHS or Department), the County's four hospital systems, and the Montgomery County Council's Chair of the Health and Human Services Committee. This supportive triumvirate is largely responsible for Healthy Montgomery's functionality and sustainability.

MCDHHS serves as the "backbone organization" of Healthy Montgomery with a considerable commitment of staff support that provides facilitation, administrative support, project management, and data management. A Special Assistant to the MCDHHS Director serves as the Healthy Montgomery Director; two full-time managerial-level staff positions provide technical expertise and experience in community engagement and program management; and part-time support is provided by a senior epidemiologist and mid-level program specialist. The County Health Officer, Chief of MCDHHS Public Health Services, also provides technical support. Both the County Health Officer and MCDHHS Director serve on the Healthy Montgomery Steering Committee (HMSC). As the backbone organization, the MCDHHS leverages additional resources and expertise within various departmental programs. For example, the Minority Health Initiatives and Programs within the Department serve on the HMSC and on action planning and implementation work groups. Department topic area experts also serve on the Healthy Montgomery work groups.

Representatives of the County's four hospital systems are also active, essential members of Healthy Montgomery. Hospital representatives who serve on the HMSC are senior level managers in their hospital's community health or health equity and wellness departments. These hospital representatives have also been dedicated members of HMSC subcommittees and Healthy Montgomery action planning and implementation work groups. The hospital systems also provide financial support that allows for the MCDHHS to contract with the Institute for Public Health Innovation (IPHI) for additional technical assistance and administrative support. In a unique arrangement, a contracted, full-time IPHI program manager works on Healthy Montgomery on-site at the MCDHHS. IPHI is the official public health institute serving the District of Columbia, Maryland, and Virginia. As a member organization of the National Network of Public Health Institutes, IPHI leverages resources and expertise from public health institutes across the country involved in similar community health improvement processes. Prior to the formation of Healthy Montgomery, the County's four hospital systems had worked collectively with the MCDHHS on other issues of shared significance. These previous experiences

fostered a collaborative relationship among the hospitals and facilitated their collective involvement in Healthy Montgomery. Also, the buy-in of the hospitals was nurtured by the community health improvement process itself, which was inclusive in the development of the process and the identification of priorities.

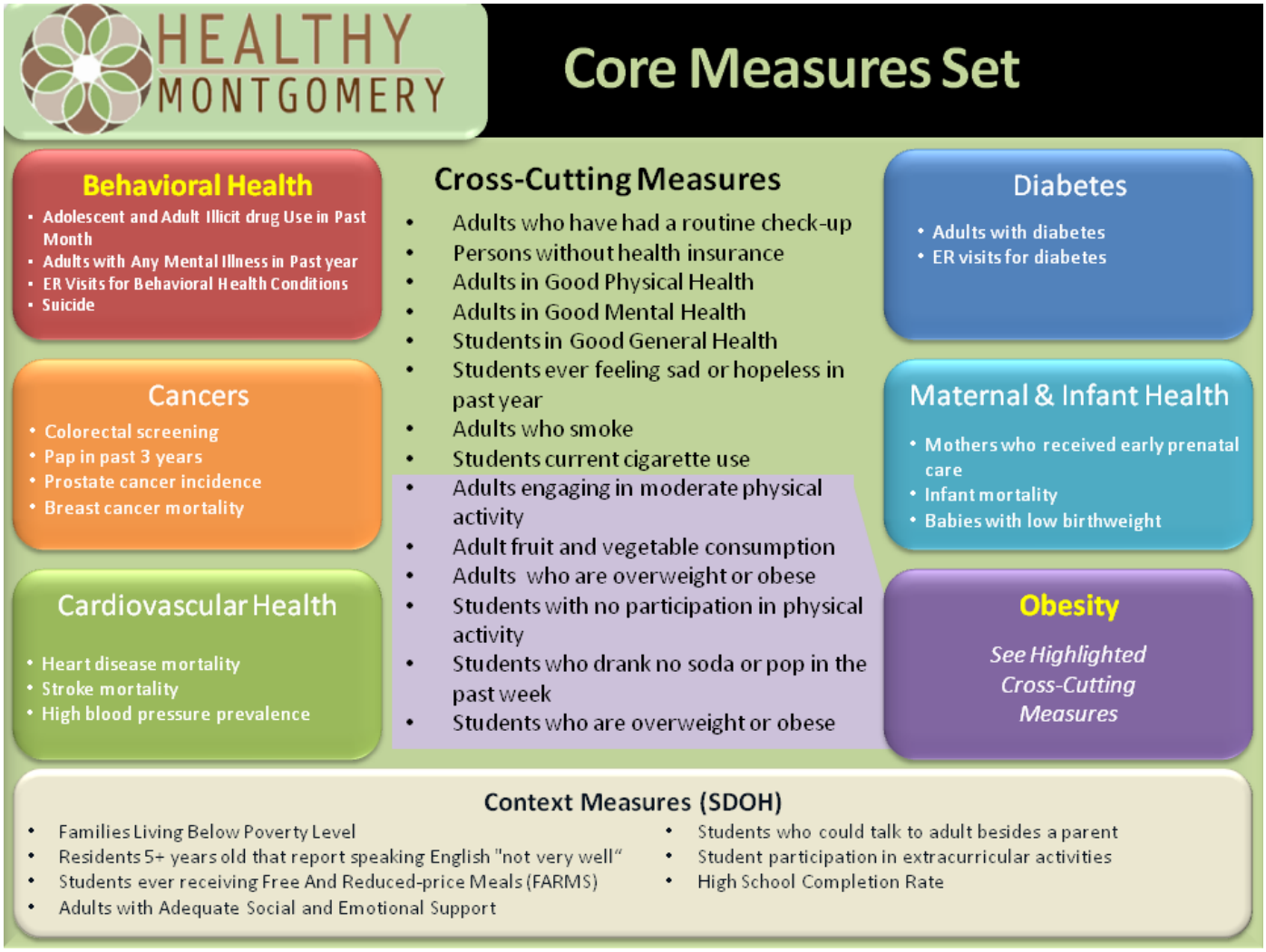
Also, the hospitals recognize the value of their involvement in Healthy Montgomery with respect to the Patient Protection and Affordable Care Act, which requires them to conduct a Community Health Needs Assessment as well as implementation plans for improving community health.

The third part of Healthy Montgomery's foundational support is provided by a Montgomery County Councilman who is Chair of the County Council's Health and Human Services Committee. Pursuant to Healthy Montgomery's Charter, the Council member serving in that role serves as Co-Chair of the HMSC. The Health and Human Services Committee is responsible for programs affecting the sick, poor, elderly, and homeless, people with disabilities and mental illness, and abused and abandoned children. The current Chair has proven to be an influential champion for Healthy Montgomery. His keen understanding of public health issues, the social determinants of health, and the connection between population health improvement and health care cost containment has made him an effective Co-Chair of the HMSC and has commanded the respect of Healthy Montgomery's cross-sector partners. It is anticipated that this role will continue to be a powerful and influential one, given the interest, commitment, experience and the skill that individuals in the position of the Council's Health and Human Services Committee Chair will bring to the Healthy Montgomery work.

With this strong foundation, Healthy Montgomery moves forward with the implementation of action plans to address behavioral health and obesity, and with its respective evaluation plans to monitor and track impacts. Healthy Montgomery developed a set of core measures (see Exhibits) that reflects its 6 priority areas (behavioral health, cancers, cardiovascular disease, diabetes, maternal and infant health, and obesity) and its intent to make impacts through implementation of strategies that address lack of access, health inequities and unhealthy behaviors.

When finalized by the HMSC, this dashboard will monitor and track progress to determine overall success of community health improvement efforts in Montgomery County.

Exhibit 1: Core Measures



Appendix C

Exhibit 2: Core Measures

No.	Recommended Core Measure for Dashboard	Priority	Measure Type	Data Source	Baseline	2008	2009	2010	2011	2012	2013	Progress Made Since Baseline
1	Adults with Adequate Social and Emotional Support	Context 1	Socio-Economic Factor	MD BRFSS	83.5	- - -	78.0	83.3				-0.2%
2	Student SR who could talk to adult besides a parent	Context 2	Socio-Economic Factor	MD YTRBS	73.9						2013 Baseline	N/A
3	Student participation in extracurriculars	Context 3	Socio-Economic Factor	MD YTRBS	72.1						2013 Baseline	N/A
4	High School Graduation Rate	Context 4	Socio-Economic Factor	ACS (ACS table S1501)	90.9	2008 Baseline	90.1	90.6	91.7	91.2		0.3%
5	Rate of Students Ever Receiving Free and Reduced-Price Meals (FARMS)	Context 5	Socio-Economic Factor	MCPS Schools at a Glance	38.4	2008 Baseline	38.1	40.5	41.5	42.4	43.3	-12.8%
6	Residents 5+ years old that report speaking English "not very well"	Context 6	Socio-Economic Factor	ACS	15.0	2008 Baseline	16.0	15.6	14.6	15.0		0.0%
7	Adults who have had a routine check-up	Cross Cutting 1	Clinical Care	MD BRFSS	85.0	*85.3*	*87.2*	*88.7*	2011 Revised Baseline	88.9		4.6%
8	Persons without health insurance	Cross Cutting 2	Clinical Care	ACS	11.6	2008 Baseline	11.5	12.5	11.7	11.9		2.6%
9	Adult SR Good Physical Health	Cross Cutting 3	Health Status/ Outcome	MD BRFSS	82.4	*79.5*	*76.2*	*82.2*	2011 Revised Baseline	80.4		-2.4%
10	Student SR General Health: Good, Very Good, Excellent	Cross Cutting 4	Health Status/ Outcome	MD YTRBS	52.3						2013 Baseline	N/A
11	Adults who smoke	Cross Cutting 5	Health Behavior	MD BRFSS	11.3	*8.1*	*7.4*	*7.8*	2011 Revised Baseline	7.5		-33.6%
12	Students SR current cigarette use	Cross Cutting 6	Health Behavior	MD YTRBS	8.5						2013 Baseline	N/A
13	Adults engaging in sufficient** physical activity *(* formerly moderate)*	Cross Cutting 7	Health Behavior	MD BRFSS	52.3	*53.0*	*52.0*	*49.1*	2011 Revised Baseline	54.4		4.0%
14	Adult fruit and vegetable consumption	Cross Cutting 8	Health Behavior	MD BRFSS	35.1	2008 Baseline	32.1	29.6				-15.7%
15	Adults who are overweight or obese	Cross Cutting 9*	Health Status/ Outcome	MD BRFSS	56.1	*51.1*	*51.6*	*54.1*	2011 Revised Baseline	55.2		-1.6%
16	Students that had not participated in physical activity for at least one hour once a week	Cross Cutting 10*	Health Behavior	MD YTRBS	43.2						2013 Baseline	N/A
17	Students that ate fruits two or more times per day and vegetables three or more times per day during the past seven days*	Cross Cutting 11*	Health Behavior	MD YTRBS	11.7						2013 Baseline	N/A
18	Students that are overweight or obese	Cross Cutting 12*	Health Status/ Outcome	MD YTRBS	20.0						2013 Baseline	N/A

KEY
SR=Self-Reported
AA=Age-Adjusted
MR=Mortality Rate
IR=Incidence Rate
HR=Hospitalization Rate
ER=ER Visit Rate

** Obesity Priority Measures overlap wilth multiple priorities and are therefore included in Cross-Cutting category.*
*** Cross-cutting measure #17 is a placeholder for an adoloscent health behavior related to nutrition - to be finalized by HM Data Project Team upon review of 2013 YTRBS data being released after June 12, 2014.*

11 measures are improving since baseline
1 measure has no change from baseline
8 measures are worsening since baseline
16 measures are either not applicable (N/A) since they only have baseline data and cannot be assessed or are missing baseline data (TBD) that are not yet available.

Continued on next page

Exhibit 2: Core Measures (continued)

No.	Recommended Core Measure for Dashboard	Priority	Measure Type	Data Source	Baseline	2008	2009	2010	2011	2012	2013	Progress Made Since Baseline
19	AA MR intoxication due to alcohol or drug use (MD SHIP)	Behavioral Health 1	Health Status/ Outcome	MD VSA-Mortality	4.4				2007-2011 Baseline			N/A
20	AA MR suicide (3-yr rolling average)	Behavioral Health 2	Health Status/ Outcome	MD VSA-Mortality	6.5	2006-2008 Baseline	7	6.9	7.3	7.0		↓ 6.2%
21	ER Behavioral Health Conditions (MD SHIP)	Behavioral Health 3	Clinical Care	MD HSCRC ER				2008-2010 Baseline				TBD
22	ER Alcohol Abuse	Behavioral Health 4	Clinical Care	MD HSCRC ER				2008-2010 Baseline				TBD
23	SR Good Mental Health	Behavioral Health 5	Health Status/ Outcome	MD BRFSS	77.2	*79.3*	*76.7*	*80.0*	2011 Revised Baseline	79.9		↑ 3.5%
24	SR Good Mental Health	Behavioral Health 6	Health Status/ Outcome	MD YTRBS	52.3						2013 Baseline	N/A
25	Mothers who received early prenatal care (3-yr rolling average)	Maternal & Infant Health 1	Clinical Care	MD VSA-Natality	82.5	*84.0*	*81.0*			Revised 2010-2012 Baseline		N/A
26	Infant MR (3-yr rolling average)	Maternal & Infant Health 2	Health Status/ Outcome	MD VSA-Mortality	6.2	2006-2008 Baseline	5.7	5.1	5.0	4.9		↑ -21.4%
27	Babies with LBW (3-yr rolling average)	Maternal & Infant Health 3	Health Status/ Outcome	MD VSA-Natality	8.2	2006-2008 Baseline	8.0	7.9	7.8	7.6		↑ -7.3%
28	Colorectal screening (Individuals who ever have had either a Blood Stool Test or Sigmoidoscopy/ Colonoscopy in the past 2 years)	Cancers 1	Clinical Care	MD BRFSS					2011 Revised Baseline	47.6		N/A
29	Pap Test History (within past 3 years-CPS guidelines)	Cancers 2	Clinical Care	MD BRFSS	83.0	*87.4*		*83.5*		2012 Revised Baseline		N/A
30	Prostate Cancer IR	Cancers 3	Health Status/ Outcome	NCI SEER (Baseline 2003-2007)	158.2	159.3	162.1	162.6				↓ 2.8%
31	MR Female Breast Cancer (3-yr rolling average)	Cancers 4	Health Status/ Outcome	MD VSA-Mortality	19.8	2006-2008 Baseline	20.3	20.6	19.8	19.6		↑ -1.0%
32	AA MR Heart Disease (3-yr rolling average)	Cardiovascular Disease 1	Health Status/ Outcome	MD VSA-Mortality	136.2	2006-2008 Baseline	130.7	127.4	123.1	119.9		↑ -12.0%
33	AA MR Stroke (3-yr rolling average)	Cardiovascular Disease 2	Health Status/ Outcome	MD VSA-Mortality	30.0	2006-2008 Baseline	29.7	29.9	28.6	27.3		↑ -9.0%
34	High Blood Pressure Prevalence	Cardiovascular Disease 3	Health Status/ Outcome	MD BRFSS	21.6		*24.5*		2011 Revised Baseline			N/A
35	Adults with Diabetes	Diabetes 1	Health Status/ Outcome	MD BRFSS	5.1	*6.2*	*7.2*	*5.6*	2011 Revised Baseline	7.0		↓ 9.8%
36	AA ER Diabetes	Diabetes 3	Clinical Care	MD HSCRC ER				2008-2010 Baseline				TBD

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SR=Self-Reported
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** Obesity Priority Measures overlap with multiple priorities and are therefore included in Cross-Cutting category.*
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Detroit Regional Infant Mortality Reduction Task Force
Detroit, Michigan

COMPETING HEALTH SYSTEMS COLLABORATE TO TRANSFORM COMMUNITIES FOR WOMEN & CHILDREN

Partnership Profile

Model of Collaboration: Formed in 2008 after the CEOs of Detroit Medical Center, Henry Ford Health System, St. John Providence Health System and Oakwood Healthcare System committed their organizations to find collaborative solutions to a community need, the Detroit Regional Infant Mortality Reduction Task Force functions as a public-private consortium that also includes public health, other agencies, and universities.

Mission and Focus: To collaboratively and measurably reduce infant mortality in the Detroit area, setting the bar for unprecedented new levels of regional partnership than can be sustained over the long-term.

Partnership Contacts:
- Dr. Kimberlydawn Wisdom, Chair, Detroit Regional Infant Mortality Reduction Task Force
- Jaye Clement, Director of Community Health Programs & Strategies

The Detroit Regional Infant Mortality Reduction Task Force, anchored by four large, competing health systems, convened to collaboratively reduce infant mortality, setting a bar for unprecedented, sustainable regional partnership through the Sew Up the Safety Net for Women and Children (SUSN) program. SUSN holds the stated goal that through "working through an unprecedented public-private partnership of Detroit's major health systems, public health, academic, and community partners, we will tighten the loose net of disconnected medical and social services for women to improve the conditions that lead to infant survival through the first year of life."

Task Force partners are:

- Henry Ford Health System, Convener*
- Detroit Department of Health & Wellness Promotion
- Detroit Medical Center*
- Greater Detroit Area Health Council
- Institute for Population Health
- Michigan Association of Health Plans
- Michigan Council for Maternal & Child Health
- Michigan Department of Community Health
- Oakwood Healthcare*
- St. John Providence Health System*
- University of Michigan School of Public Health
- Wayne County Health Department

Three primary strategies were employed to reduce disparities and the confounding social determinants of health related to infant mortality. The Exhibit portrays the objectives and some outcomes of SUSN.

1) Transforming Place: The Task Force's utilization of community health workers (CHWs) has eliminated preventable infant deaths among participating women in three Detroit neighborhoods. Neighborhood residents experience a disproportionate burden of poverty, stressors, diseases, health inequities, social isolation and limited access to resources. Building upon existing relationships and trust between CHWs with organizations and the community, SUSN links women between disconnected clinical and social services to address these matters.

*participating health systems

While SUSN cannot geographically relocate women, through the engagement of CHWs as change agents, we are transforming place. Data analysis describes the effectiveness of CHWs in shaping residents' view of opportunities to thrive within these conditions. Compared with Detroit's overall infant mortality rate of 15.0/1000 for black mothers, SUSN participants did not experience any preventable infant loss. The mean birth weight for the 191 babies included in the initial analysis was 6.79 pounds with average gestation of 38.3 weeks. At this writing the 3-year project has enrolled 364 of the anticipated 375 pregnant participants, enrolled 443 of the anticipated 1,125 non-pregnant women, and engaged more than 700 non-pregnant women and family members as well. (See the Exhibit for more information.)

2) Translating Place: Many providers serving Medicaid populations aren't familiar with the socially complex challenges and environments of our target population. The Task Force is deploying a CME-approved healthcare equity training that harnesses regional and national indicators and moves through a case study shifting from theoretical to applicable. Participants learn of underlying causes of social and environmental factors that contribute to clinical outcomes. The workshop includes discussion and problem solving exercises that foster relationships between public and private health care professionals, promotes a sustainable platform for communication, and strengthens regional capacity to improve infant survival. Evaluations reveal statistically significant changes in beliefs and intentions to participate in efforts to increase quality of care for minority patients, willingness to work with community groups to address a local health problem, and awareness of stereotypes and communication skills that contribute to improved healthcare delivery. For example, of the 389 professionals to participate in the healthcare equity training, 97% plan to incorporate the information learned in to their respective practices.

3) Transcending Place: A key objective is to engage the community through digital tools, promoting pre- and inter-conception health information, and prenatal care recommendations. This component focuses on the application of digital outreach and the opportunities for engaging CHWs in communication strategies. Information gathered in focus groups and qualitative interviews informed the decision to position CHWs at the helm of digital outreach. The social marketing campaign empowers women to access local resources addressing social determinants, supports program goals, and provides engagement of CHWs with a broader audience, regardless of place. Additional data analysis will demonstrate changes in engagement and reach as a result of CHW's role in the digital outreach campaign. Since launching the community-based website in July 2013, more than 7500 users visited for information gathering, story sharing and resource finding.

See the Exhibit, which portrays results of the SUSN program's first three years.

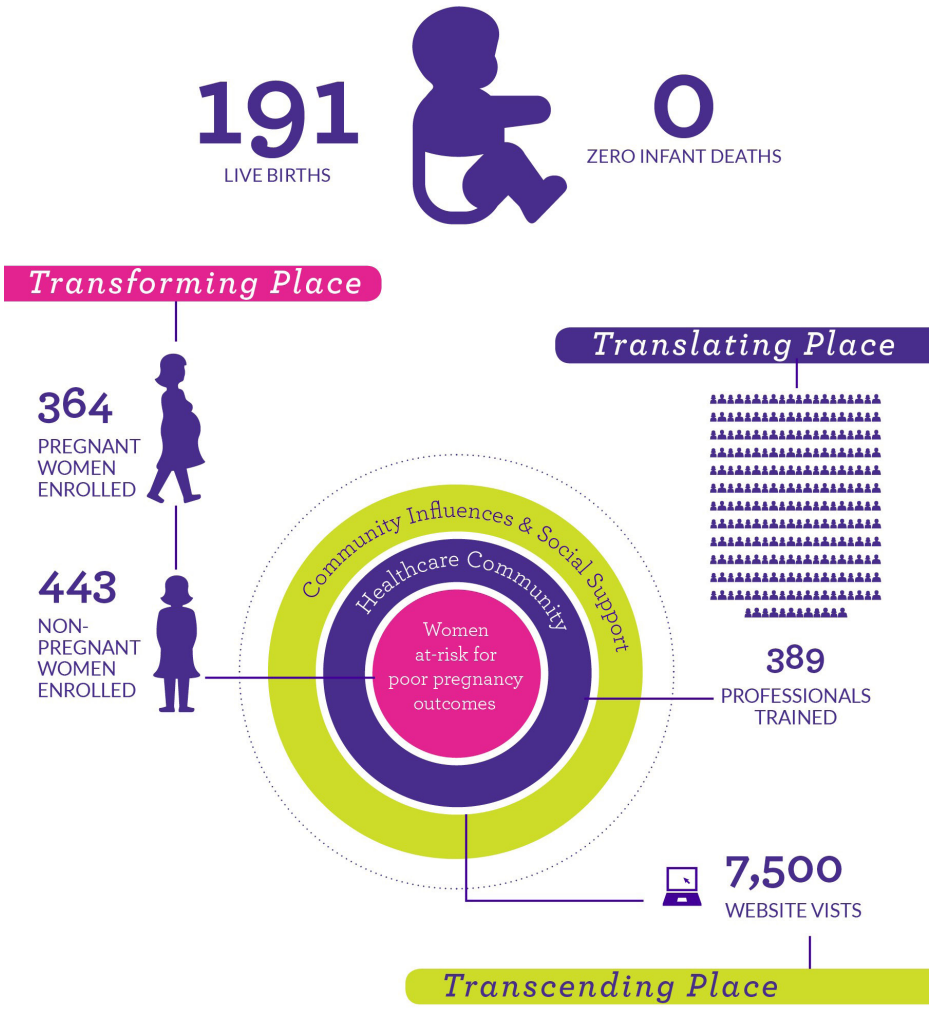
Task Force efforts to overcome the challenges of place resulted in the realization of several challenges and lessons learned. These include:

- Understanding program participants' framework for pursuing successful birth outcomes, which led to renaming the initiative "Women-Inspired Neighborhood (WIN) Network: Detroit;"
- Continuing program activities while constantly troubleshooting;
- Pursuing policy and systems-level changes;
- Engaging business and education stakeholders;
- Maintaining engagement with high-level partners; and
- Ensuring program sustainability.

Sustainability planning has been key. The Task Force has consistently worked to explore ongoing, systemic processes for the training, certification and reimbursement of CHWs as members of the health care team. Through best practice research, employer surveys, payment-design discussions with health plans, contribution to policy efforts and development of a standardized curriculum with the Michigan Community Health Worker Alliance, the Task Force is taking steps to ensure the Sew Up the Safety Net approach will be replicable, scalable, sustainable – and ultimately not dependent on grant dollars. In fact, the project is of such high priority for its four participating health systems that their CEOs discuss progress and sustainability strategies at scheduled meetings.

In every challenge, it is our strong, meaningful partnerships that continue to "Sew Up the Safety Net."

Exhibit: Detroit's Sew Up the Safety Net for Women & Children Results 2012-2014



DATA SUMMARY

Data reflected is as of August 2014. Data collection and analysis are ongoing at the time of this publication, the analysis included n=143 of the 191 births accounted for by Sew Up the Safety Net for Women & Children.

10.7 WEEKS
AVERAGE GESTATIONAL AGE AT FIRST PRENATAL VISIT WITH
84%
IN FIRST TRIMESTER

38.3 WEEKS
AVERAGE GESTATIONAL AGE AT BIRTH WITH
89%
FULL-TERM

6.79 POUNDS
AVERAGE BIRTH WEIGHT OF INFANTS WITH ONLY
12%
AT LOW BIRTH WEIGHT

13%
OF BABIES USED NICU, MOSTLY MULTIPLE BIRTHS AND STAYING LESS THAN 1 WEEK

Hearts Beat Back: The Heart of New Ulm Project
New Ulm, Minnesota

LEVERAGING DATA TO MOBILIZE A COMMUNITY

Partnership Profile

Model of Collaboration: The Heart of New Ulm Project is a community collaborative effort established by the Minneapolis Heart Institute Foundation through a grant from Allina Health.

Mission and Focus: The Heart of New Ulm Project is a 10-year initiative designed to reduce the number of heart attacks that occur in the New Ulm, Minnesota, area.

Partnership Contacts:
- Jackie Boucher, Senior Vice-President and Chief Operating Officer, Minneapolis Heart Institute Foundation
- Rebecca Lindberg, Director, Population Health, Minneapolis Heart Institute Foundation

The project was modeled after other successful community-wide cardiovascular disease (CVD) research initiatives but with one major notable difference. The primary population-level surveillance tool is the electronic health record (EHR), with supporting data from other methodologies (e.g., phone/mail surveys) and sources (e.g., public health department).

The rural city of New Ulm has one hospital and clinic, and more than 90% of the population has data within the EHR at New Ulm Medical Center (NUMC). This makes the EHR the ideal repository for surveillance and registry data. However, EHR data has some limitations such as being designed to aid in diagnosing and treating disease, not preventing it, thus lacking systematic measures on behavioral risk factors for CVD. Additionally, many individuals wait to seek care until they are ill, which can lead to gaps in data.

To supplement the EHR data and to identify more CVD risk factors within the target population (40-79 year olds), the project conducted community screenings in 2009 (baseline year). A comprehensive community diagnosis was necessary to direct programmatic resources toward the areas of greatest need. Additional screenings were conducted in 2011 and 2014 to assess progress and make important strategy adjustments (e.g., revise interventions, target different sub-groups within the target population). A final screening will be conducted in 2018 to assess 10-year outcomes.

Baseline screenings successfully reached approximately 40% of the target population. Collaboration with community leaders and stakeholders has been critical to proactively reach the target population. As the sole healthcare system and owner of the EHR, NUMC was uniquely positioned to be a health leader in the project and was a critical stakeholder to engage in screenings. Their leadership role in the community and support of the project has been essential to mobilizing the community and contributing to the project success.

The community diagnosis identified that obesity was very problematic in New Ulm, along with associated medical risks such as metabolic syndrome (10% higher than national estimates). This was supported by findings from screening data on low fruit/vegetable consumption and significant underutilization of preventive medical therapies (e.g., aspirin, statin and blood pressure medications) among those at risk.

Exhibit 1 highlights the community diagnosis and plan developed to address the health issues identified. While data identified CVD risk factors across various groups within the target population, the key to successfully mobilizing an entire community has been strategically sharing the data with stakeholders. Given the project impacts various sectors — clinical, worksite and community — as well as environments, it was important to include all stakeholders in the conversations. Ideas were presented on how to improve the health of the population, feedback was gathered related to the ideas, messages for programs or social marketing campaigns were pilot tested with intended audiences (e.g., focus groups), and then interventions were implemented and evaluated. A comprehensive social marketing strategy to engage high proportions of the community was also part of the intervention plan.

For example, results sent to individuals after their screenings helped empower them to take action. Providers received the results via the EHR, which expanded data available to treat patients. At the clinic level, data was used to target high-risk population groups systematically. Clinical leadership at NUMC, the steering committee and the community members (through newspaper articles, e-newsletter, local cable access TV show, etc.) received tailored messaging around the aggregate results (i.e., community diagnosis, progress and areas for improvement). Annually the project has shared success stories, aggregate data, and current and future plans at a community summit and through an annual report that is delivered to every household.

Through ongoing data sharing and focus groups with the community, as well as clinical leadership and steering committee engagement, feedback has been gathered on the types of interventions that could be designed to improve health. Ongoing surveys and assessments were utilized once the interventions were implemented to determine changes in CVD risk factors and modifications needed to improve existing interventions. Follow-up screenings and regular review of EHR population-level data determined changes needed to continue to impact key health metrics within the population.

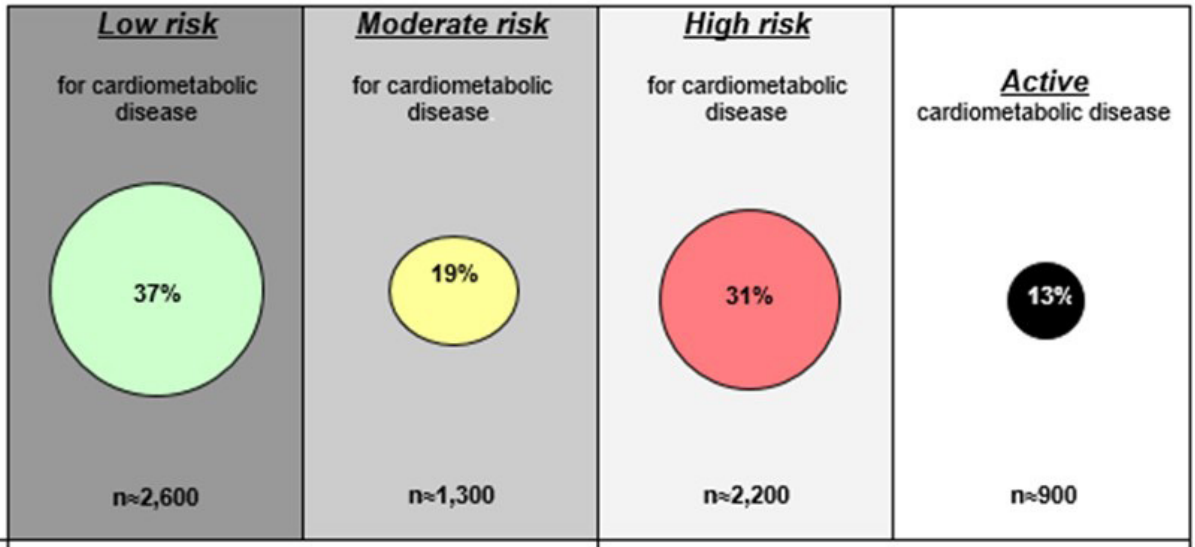
Data suggests the strategies are working. Screening data from 2011 (2-year outcomes) observed statistically significant improvements in lifestyle behaviors (i.e., decrease in tobacco use, increases in fruits and vegetable consumption and physical activity levels, and reductions in stress). Screenings to re-assess lifestyle behaviors are in progress. Exhibit 2 provides 5-year project outcomes for CVD risk factors based on EHR data. Significant improvement in blood pressure and lipids were noted over 5 years. The bulk of these population-level improvements seem to be driven by better risk factor control among the sizeable number of individuals who were not at goal at baseline.

The use of data to mobilize partners and the community has been critical to the project's success. Data does not have impact unless used strategically to facilitate change. It helps identify the risks in a target population, evaluate change, and provide important information that can be used to communicate progress or need for additional change. Data can also provide support with key partners and funders (e.g., demonstrate impact). Through collaborative and coordinated action, transparent use and communication of data, and ongoing dialogue and partnerships across various sectors, disciplines and the community, success has been achieved.

Appendix C

Exhibit 1

Community diagnosis and estimated cardiometabolic risk stratification in the population of 56073 zip code residents age 40–79 years (n ≈ 7,000), along with associated population and individual level general intervention strategies in the Heart of New Ulm Project.



Individual/ Medical level strategies	• Advanced CVD risk assessments (particularly for moderate risk individuals)	• Telephonic coaching (particularly for high risk individuals) • Advanced training, clinical decision making aids, and panel feedback reports (for medical providers)
Population/ Community level strategies	• Biannual cardiometabolic risk factor screenings • Nutrition environment supports • Worksite wellness supports • Lifestyle-focused community/neighborhood challenge programs • Community education and health-related social marketing campaigns	

Active cardiometabolic disease includes type 2 diabetes and/or cardiovascular disease.

High risk = participants with metabolic syndrome, or Reynolds Risk Score ≥20%, or Framingham Diabetes Score ≥15%.

Low risk = participants without metabolic syndrome, and Reynolds Risk Score <5%, and Framingham Diabetes Score <5%.
CVD = cardiovascular disease

Reference: VanWormer JJ, Johnson PJ, Pereira RF, Boucher JL, Britt HR, Stephens CW, Thygeson NM, Graham JJ. The Heart of New Ulm Project: Using community-based cardiometabolic risk factor screenings in a rural population health improvement initiative. Population Health Management. 2012;15:135-143.

Exhibit 2: Five-Year Outcomes Based on EHR Data for Target Population

Prevalence of Modifiable CVD Risk Factors from the EHR for HONU Target Area Residents Age 40-79				
	2008/09 n = 7222	2010/11 n = 7432	2012/13 n = 7584	p-value
Systolic BP (mmHg)	125.7 ± 0.2	125.1 ± 0.2	124.7 ± 0.2	<0.001
Diastolic BP (mmHg)	74.7 ± 0.1	73.7 ± 0.1	72.7 ± 0.1	<0.001
BP at goal (<140/90 mmHg)	78.7	81.3	84.3	<0.001
BP medication	33.5	39.1	44.1	<0.001
LDL (mg/dL)	115.0 ± 0.5	111.5 ± 0.4	112.5 ± 0.4	<0.001
LDL at goal (< 130 mg/dL)	68.0	72.4	72.1	<0.001
HDL (mg/dL)	50.7 ± 0.2	49.1 ± 0.2	48.9 ± 0.2	<0.001
HDL at goal (> 40 mg/dL men, > 50 mg/dL women)	64.0	58.9	57.8	<0.001
Lipid medication	19.8	24.2	28.0	<0.001
Triglycerides (mg/dL)	140.4 ± 1.1	133.8 ± 1.0	132.4 ± 1.2	<0.001
Triglycerides at goal (<150 mg/dL)	66.4	68.7	70.1	<0.001
BMI (kg/m2)	30.1 ± 0.1	30.1 ± 0.1	30.1 ± 0.1	0.534
Not Obese (< 30 kg/m2)	55.9	55.6	55.4	0.474
Glucose (mg/dL)	105.6 ± 0.4	106.6 ± 0.5	109.4 ± 0.5	<0.001
Glucose at goal (<100 mg/dL)	54.3	55.4	47.9	<0.001
Aspirin Medication	23.3	30.0	36.0	<0.001
Non-Smoking	86.2	86.1	86.3	0.080

Continuous outcomes are reported as mean ± standard error, and categorical outcomes are reported as percent of sample. P-values are a test for trend.
Reference: Sidebottom AC, Sillah A, Vock DM, Miedema MD, Pereira R, Benson G, Boucher JL, Knickelbine T, VanWormer JJ. Improvements in Cardiovascular Disease Risk Factors after Five Years of a Population-Based Intervention: The Heart of New Ulm Project. AHA Abstract 2014

Healthy Monadnock 2020
Keene, New Hampshire

ENGAGEMENT THROUGH EVALUATION

Partnership Profile

Model of Collaboration: Founded in 2007 by the Cheshire Medical Center with funding from the Cheshire Health Foundation, grants and private foundations, Healthy Monadnock utilizes a "champions" program through which partner agencies pledge to live, share and inspire others to follow the goals and values of Healthy Monadnock.

Mission and Focus: The mission of Healthy Monadnock 2020 is to make the Monadnock region the healthiest community in the nation through engagement of champions (partners, organizations, schools and individuals) working to make the healthy choice the easy choice. Focus areas include healthy eating, active living, education, livable wages/jobs and mental well-being.

Partnership Contact:
- Linda Rubin, Director of Healthy Community Initiative, Healthy Monadnock

Creating balanced scorecards (see Exhibit 1) for the goals of the health community initiative tied to specific metrics and targets used to measure progress, and simultaneously integrating this tool into the action planning process, has been an important feature for aligning and engaging partners with Healthy Monadnock's goals and strategies.

Cheshire Medical Center/Dartmouth-Hitchcock Keene has an ongoing contract with Antioch University New England (AUNE) to provide evaluation services for the Healthy Monadnock 2020 (HM2020) initiative. These efforts involve the routine monitoring — at the county, state, and national levels — of 27 healthy eating, active living, and community health-status and quality of life-related indicators (see Exhibit 1) through existing, publically available, epidemiological data (e.g., BRFSS, CDC mortality data) as well as through HM2020's bi-annual Community Survey (CS), a random digital survey of 625 Cheshire County residents that the AUNE evaluation team undertakes to address gaps in epidemiological data. The CS includes fruit and vegetable consumption and physical activity indicators, individual mental and physical health and well-being indicators, and community health and social connection indicators. The team collects CS data bi-annually and last collected it in May 2014.

Targets for each indicator were determined by the Healthiest Community Advisory board in cooperation with community stakeholders in 2008, and reviewed and updated in 2013. The indicators and targets are regularly updated *by* the community and shared *with* the community as a way to increase awareness of the initiative and its progress, engage implementation partners (Champions) and align community partners with the goals and strategies of the initiative.

The evaluation team subscribes to a participatory, action-oriented evaluation model (utilization-focused evaluation [UFE]; Patton, 2008) and since 2008, engages key stakeholders — project staff, community partners and stakeholders, and the Healthiest Community Advisory board (HCAB) — in the design of the evaluation plan, project database, and data dashboards; negotiates the ongoing data collection, entry, and extraction procedures with project partners; manages the data and conducts statistical analyses; facilitates utilization of the findings to improve the program; and develops the evaluation reports, presentations, and publications. The evaluation

team provides project stakeholders and partners with evaluation planning and implementation support and technical assistance through facilitated community of practice structure that includes one-on-one partner meetings, as well as bi-annually evaluation-focused meetings with the initiative's Healthiest Community Advisory Board, and monthly meetings with project staff.

The HM2020 evaluation strategy involves three levels of performance measurement: (1) stakeholder collaboration and capacity development, (2) short-term outcomes, and (3) long-term outcomes/impacts. The evaluation team uses the PARTNER tool — an online social network survey and analysis tool — to monitor HM2020 relationships, as well as the perceived contributions, capacities, and outcomes of the HM2020 network. PARTNER also allows the evaluation team to assess the effectiveness of HM2020's work as the "backbone" of this collective impact initiative.

The Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) tool was developed and piloted by the evaluation team to monitor the short-term outcomes of program, policy, system and environmental changes (PPSEs) implemented by HM2020 community partners. They are currently completing pilot testing of this tool, which is based on Glasgow's influential public health framework (Glasgow, Vogt, & Boles, 1999). Based on community partner project records and evaluation data, the scholarly best practice/evidence-based practice literature, and key informant interviews, this tool allows the evaluation team to capture not only key short-term outcomes, but also an estimate of the effectiveness, level of adoption (by sites and staff), quality of implementation, and maintenance/sustainability associated with each PPSE. We currently use this tool to monitor increased access to (1) smoke- or tobacco-free environments, (2) environments with healthy food and/or beverage options, and (3) opportunities for physical activity across all PPSEs. The RE-AIM tool is administered and reported annually.

The evaluation team also works with Champions to design and maintain a data dashboard of key indicators, to provide the project with ongoing feedback about program challenges and successes. Through the various project meetings, the evaluation team meets with partners to highlight trends, examine and learn from variations in program performance over time, and strategically prioritize learning opportunities and quality improvement possibilities.

Appendix C

Exhibit 1 : Healthy Monadnock 2020 Indicators

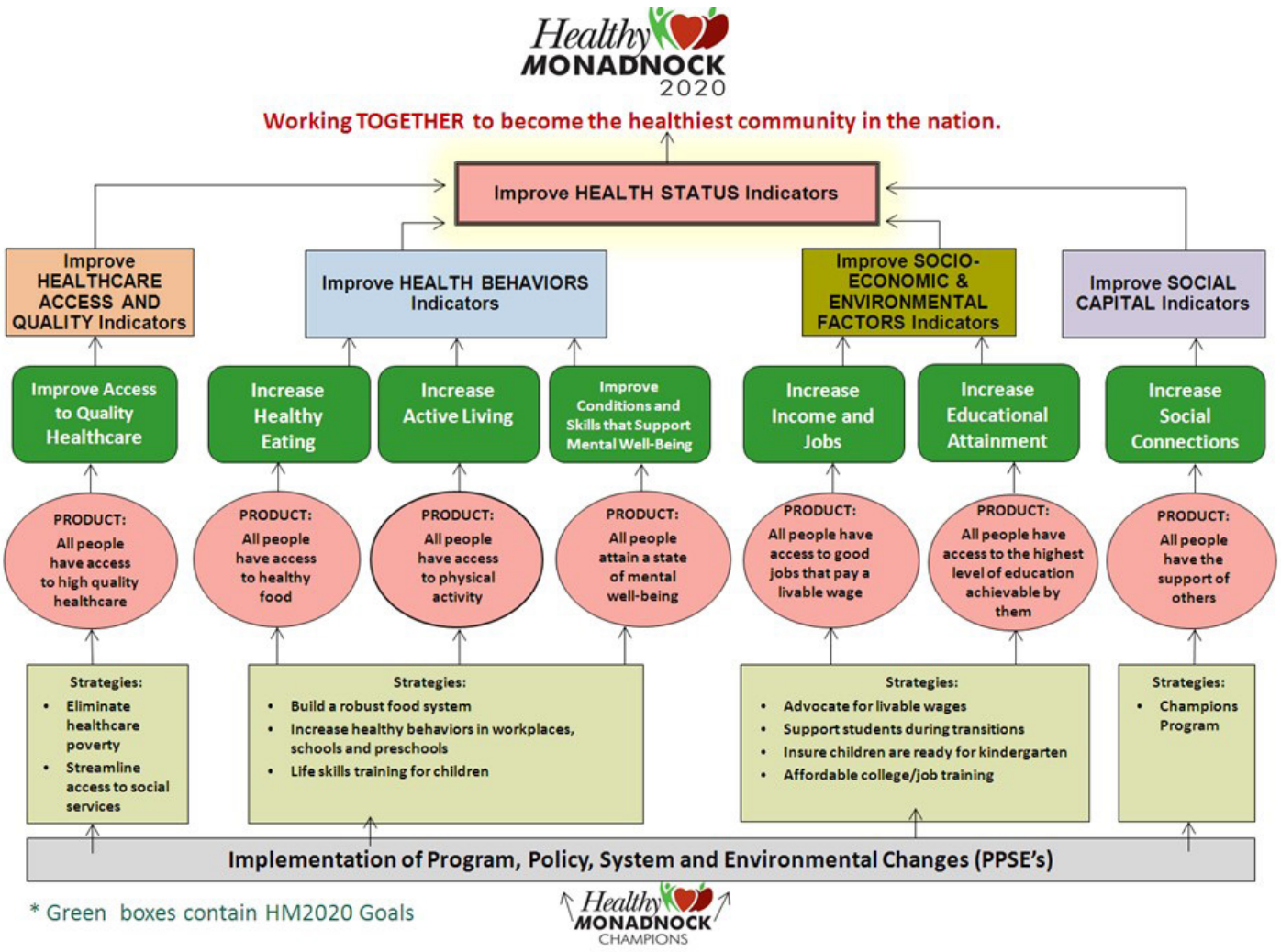
HM2020 Indicator	Target Area	Baseline	Healthiest Community Target	Cheshire County	N.H.	U.S.	Cheshire vs U.S.	Trend
Adults who smoke (2012)	*Health Behaviors*	21.0% (2005)	12.0%	18.5%	17.2%	19.6%		BETTER
Youth smoking (2011)	*Health Behaviors*	18.1% (2009)	10.0%	18.1%	18.7%	18.1%		SAME
Adult binge drinking (2012)	*Health Behaviors*	21.8% (2011)	14.0%	18.2%	17.3%	16.9%		BETTER
Chlamydia Rate (per 100,000) (2012)	*Health Behaviors*	135.9 (2005)	150	275.6	233	456.7		WORSE
Any physical activity w/n 30 days (2012)	*Health Behaviors*	82.3% (2005)	90.0%	82.5%	80.0%	76.9%		WORSE
Met physical activity guideline (2011)	*Health Behaviors*	25.6% (2011)	50.0%	25.6%	22.3%	21.0%		SAME
Adults who eat 5+ fruits and vegetables daily (2009)	*Health Behaviors*	31.8% (2005)	50.0%	27.0%	28.0%	23.0%		WORSE
Very confident getting health info (2012)	*Health Behaviors*	86.0% (2010)	94.0%	83.0%	N/A	N/A	N/A	WORSE
Health provider main source health info (2012)	*Health Behaviors*	81.0% (2010)	95.0%	88.0%	N/A	N/A	N/A	BETTER
Residents with health insurance (2012)	*Health Care Access & Quality*	87.7% (2005)	100.0%	84.7%	84.2%	79.6%		WORSE
Have personal doctor or provider (2012)	*Health Care Access & Quality*	83.4% (2011)	100.0%	78.0%	N/A	N/A	N/A	WORSE
Adults visiting dentist (any reason) (2012)	*Health Care Access & Quality*	75.6% (2006)	80.0%	71.9%	73.1%	67.2%		WORSE
Adults with good or better health (2012)	*Health Status*	91.5% (2005)	95.0%	83.5%	86.5%	82.9%		WORSE

Continued on next page

Exhibit 1 : Healthy Monadnock 2020 Indicators (continued)

HM2020 Indicator	Target Area	Baseline	Healthiest Community Target	Cheshire County	N.H.	U.S.	Cheshire vs U.S.	Trend
Frequent mental health distress (2012)	*Health Status*	7.9% (2005)	6.0%	8.4%	N/A	N/A		WORSE
All cardiovascular disease mortality (per 100,000) (2010)	*Health Status*	178.1 (2005)	187.0	160.9	152.7	179.1		BETTER
Suicide mortality (per 100,000, 3-yr average) (2008-2010)	*Health Status*	9.0 (2005)	4.8	14.7	13.7	12.1		WORSE
Adults at healthy weight (2012)	*Health Status*	41.1% (2005)	50.0%	39.0%	37.0%	35.0%		WORSE
Adults with diabetes (2012)	*Health Status*	6.7% (2005)	5.0%	8.7%	N/A	N/A		WORSE
Community rating (good or better) (2012)	*Social Capital*	93.0% (2010)	100.0%	93.0%	N/A	N/A	N/A	SAME
Volunteerism (2012)	*Social Capital*	67.0% (2010)	75.0%	67.0%	N/A	N/A	N/A	SAME
Friends over to home (at least once a month) (2012)	*Social Capital*	66.0% (2010)	72.0%	71.0%	N/A	N/A	N/A	BETTER
Poverty rate (all ages) (2012)	*Socio-economic and Environmental*	11.4% (2011)	8.0%	11.4%	9.7%	15.9%		SAME
Children In Poverty (2012)	*Socio-economic and Environmental*	14.3% (2011)	8.0%	15.3%	13.6%	22.6%		WORSE
Unemployment rate (2012)	*Socio-economic and Environmental*	3.2% (2005)	4.0%	5.3%	5.5%	8.1%		WORSE
Percent 9th graders that graduate within 4 yrs (20010-2011)	*Socio-economic and Environmental*	86.0% (2009)	91.0%	86.0%	86.0%	N/A	N/A	SAME
Attended some college (2012)	*Socio-economic and Environmental*	56.7% (2011)	72.0%	67.9%	49.2%	46.3%		BETTER
Air quality (days good) (2012)	*Socio-economic and Environmental*	185 (2005)	300	288	N/A	N/A	N/A	BETTER

Exhibit 2


Healthy MONADNOCK 2020
Working TOGETHER to become the healthiest community in the nation.
Improve HEALTH STATUS Indicators
Improve HEALTHCARE ACCESS AND QUALITY Indicators
Improve HEALTH BEHAVIORS Indicators
Improve SOCIO-ECONOMIC & ENVIRONMENTAL FACTORS Indicators
Improve SOCIAL CAPITAL Indicators
Improve Access to Quality Healthcare
Increase Healthy Eating
Increase Active Living
Improve Conditions and Skills that Support Mental Well-Being
Increase Income and Jobs
Increase Educational Attainment
Increase Social Connections
PRODUCT: All people have access to high quality healthcare
PRODUCT: All people have access to healthy food
PRODUCT: All people have access to physical activity
PRODUCT: All people attain a state of mental well-being
PRODUCT: All people have access to good jobs that pay a livable wage
PRODUCT: All people have access to the highest level of education achievable by them
PRODUCT: All people have the support of others
Strategies:
• Eliminate healthcare poverty
• Streamline access to social services
Strategies:
• Build a robust food system
• Increase healthy behaviors in workplaces, schools and preschools
• Life skills training for children
Strategies:
• Advocate for livable wages
• Support students during transitions
• Insure children are ready for kindergarten
• Affordable college/job training
Strategies:
• Champions Program
Implementation of Program, Policy, System and Environmental Changes (PPSE's)
* Green boxes contain HM2020 Goals
Healthy MONADNOCK CHAMPIONS

Healthy Cabarrus
Kannapolis, North Carolina

COLLABORATIVE ASSESSMENT AND ACTION PLANNING PROCESSES

Partnership Profile

Model of Collaboration: Healthy Cabarrus, formed in 1997, is a community partnership housed and administered through Cabarrus Health Alliance (local health authority) and certified as a Healthy Carolinians Partnership.

Mission and Focus: The mission of Healthy Cabarrus is to unite and commit time, talents, and financial resources to create a healthy community and a hopeful future for all citizens. Focus areas include child maltreatment, illicit drug use, diabetes and obesity.

Partnership Contact:
- Barbara Sheppard, Executive Director

Healthy Cabarrus has effectively responded to community health needs for over 15 years as a result of a cyclical collaborative process that keeps partners engaged throughout all stages of program planning and implementation (see Exhibit). We have found that partners who have been involved throughout the early stages of project development are more deeply invested and committed to the coalition because they have a greater sense of how their work complements the larger vision and mission of Healthy Cabarrus.

The mission of Healthy Cabarrus is to unite and commit our time, talents, and financial resources to create a healthy community and a hopeful future for all citizens. At the heart of this mission is a commitment to action that is responsive to the community's documented needs. Every four years, Healthy Cabarrus identifies health-related priorities through a comprehensive Community Needs Assessment (CNA). In 2012, the CNA included a consumer survey of 1,600 households, a key informant survey of nearly 100 leaders in Cabarrus County health and human services, a health resource inventory, and a review of county-level data and the state of environmental health.

A diverse Community Planning Council reviews the assessment's findings and works together to identify priorities. Members include representatives from health and human services, the faith community, education, city and county government, foundations, businesses, and community volunteers. Healthy Cabarrus seeks partners who are able to listen, analyze, think clearly and creatively, work well with people, and are tolerant of different views. The CNA is widely disseminated throughout the community so as to adequately share important information and to bring our community together. Over 50 presentations were made to diverse community groups following the 2012 Assessment.

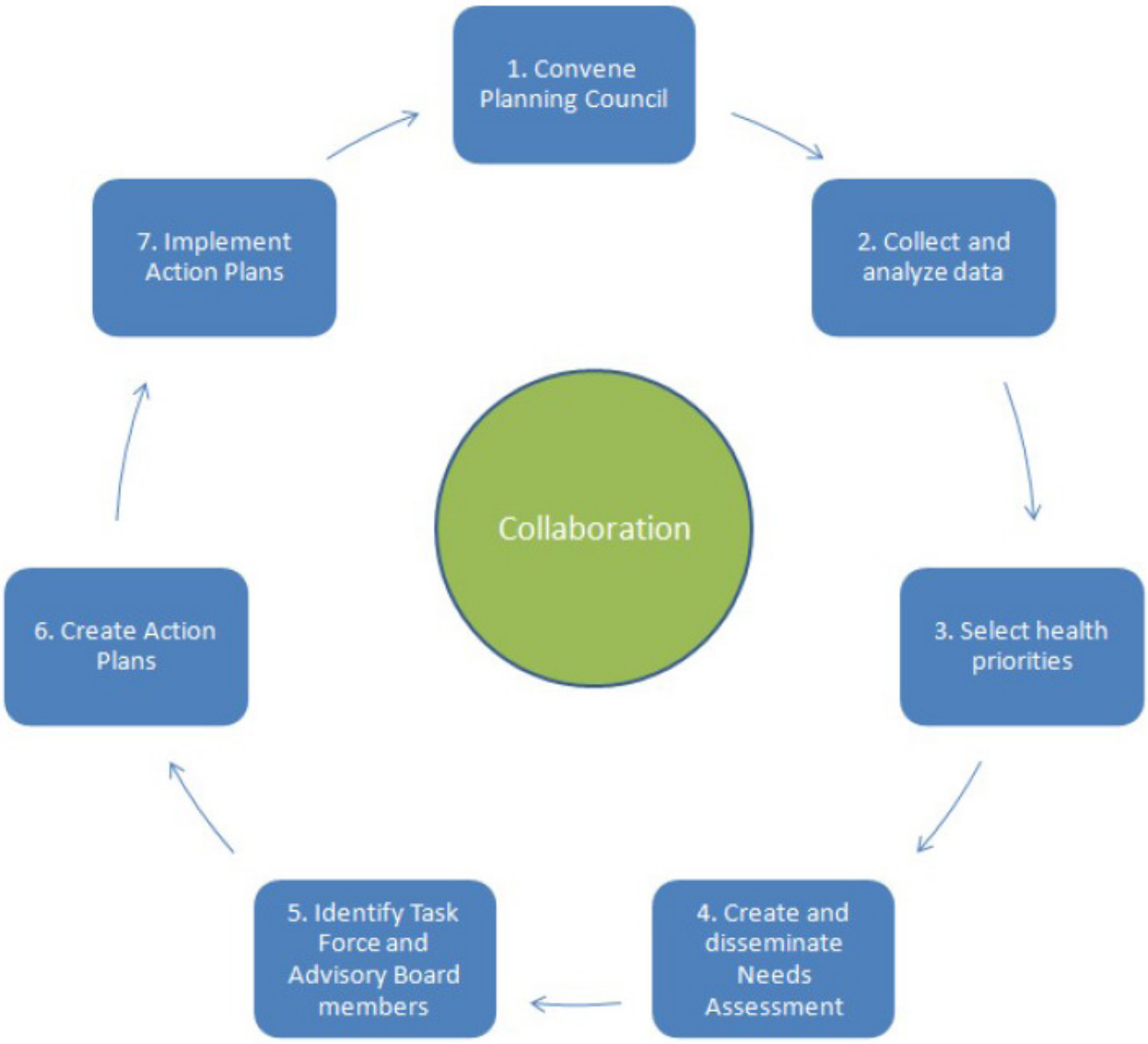
Once priorities have been determined, individuals with relevant expertise are recruited to serve on topic-specific Task Forces that develop and implement action plans. Healthy Cabarrus recruits stakeholders who have expertise in the prioritized issues, access to the target population, or who are affected by the issues. The Planning Council transitions into an Advisory Board that oversees this work and continues to meet every other month. The entire process is governed by a six-member Executive Board.

By providing a forum for community stakeholders to convene on a regular basis and participate in meaningful action, Healthy Cabarrus has created a community-wide cultural norm of collaboration. Engaging partners throughout the process fosters a strong group dynamic of trust and accountability and stakeholders are able to see how collaboration helps us achieve our common goals.

An example of how this process has resulted in enduring systemic improvements can be seen in the creation of the county's Community Care Plan for low-income, uninsured residents. The 2000 Community Needs Assessment identified access to care as a critical issue, and a task force consisting of leading health and human service providers in the area was created. This group participated throughout the planning and implementation of the project. As a result, Healthy Cabarrus was able to map out existing resources, identify gaps, create flowcharts depicting how people access care, and work together to provide needed services and medications. The resulting Community Care Plan, which links individuals to primary care providers and coordinates their care, has endured for the past 13 years and continues to serve nearly 1,000 of our most at-risk residents. This is a direct result of the collaborative efforts of Healthy Cabarrus. The program could not continue without the commitment of community agencies and health care providers who volunteer their time to serve these patients free of charge.

The cyclical assessment, action planning, and implementation process has an additional benefit in that it facilitates flexibility that has allowed for the coalition's long-term sustainability. Every four years, we assess our progress, realign our activities to meet the community's current needs, and bring in new partners. Therefore, we are able to continuously foster collaboration and forward momentum. The transparency of these standardized processes engenders trust, respect, and a long-term commitment among partners.

Exhibit: Healthy Cabarrus Community Health Planning Process



Transforming the Health of South Seattle and South King County
Seattle, Washington

TRANSFORMING HEALTH IN KING COUNTY, WASHINGTON

Partnership Profile

Model of Collaboration: Transforming Health began as a partnership in 2010 between Seattle Children's Hospital, Public Health – Seattle & King County and the Healthy King County Coalition. The partnership formalized its work via funding from the CDC Community Transformation Grants and utilizes a contract among its primary partners.

Mission and Focus: To transform the health of South Seattle and South King County; focus areas include physical activity, healthy food and drink, and tobacco-free environments.

Partnership Contact:
- Brian Saelens, Principal Investigator, Seattle Children's Hospital

Transforming the Health of South Seattle and South King County, Washington, (Transforming Health) is a collaborative effort to change policies, systems, and environments (PSE) so all residents can be physically active, have access to healthy foods and beverages, and live in tobacco-free environments. With funding from the Centers for Disease Control and Prevention's Community Transformation Grant program, Transforming Health builds on many years of successful PSE work in King County.

Transforming Health is led by Seattle Children's Hospital, Public Health – Seattle & King County (PHSKC), and the Healthy King County Coalition (HKCC). Representatives from each of the three lead organizations sit on the Executive Team, which is tasked with Transforming Health governance. We believe that the finest feature of Transforming Health is the integration of community engagement into this chronic disease prevention work through inclusion of HKCC as a leadership partner and funding of community-based organizations.

HKCC, established in 2010, is a partnership of over 50 diverse individuals, community organizations, and public institutions working to improve the health of low-income people and underrepresented communities and to reduce health inequities. It promotes equitable access to opportunities for healthy food, physical activity, and smoke-free environments through PSE change and community engagement. HKCC is incorporated into the leadership structure of Transforming Health to ensure continued focus on health equity and community engagement. While funds from Transforming Health support HKCC, the strategic direction of HKCC is determined by the independent HKCC Governance Team.

Transforming Health also supports 21 subcontracts with local organizations, school districts, cities, and institutions; five of these subcontracts are with community-based organizations to build community leader and resident capacity to support PSE change.

This combination of an area-wide coalition and focused community capacity development has the following benefits:

- HKCC has intimate knowledge and strong relationships with its communities, allowing it to rapidly convene multi-sector partners to support PSE changes.
- As a member of the Transforming Health Executive Team, the HKCC Program Manager assures that equity and community needs are considered on par with other priorities.
- HKCC's community ties have helped Children's and PHSKC access community partners, resulting in deeper understanding of community history, culture, and dynamics and how local contexts affect adoption of successful approaches from other communities. For example, HKCC worked with the community-based organization Global to Local (also funded by Transforming Health) to provide community input and support for recent policy change that increases access to single gender recreation and physical activity.
- HKCC facilitates leadership development trainings that have increased the community engagement skills of local community leaders; leaders from two of the five Transforming Health-funded community capacity development projects attended the first series of trainings. As a result, Global to Local leaders developed community-led strategies for infusing health into city planning efforts for a new light rail station. Got Green community leaders gained community engagement skills and worked to increase access to locally sourced healthy foods and spur policy change to generate economic development.
- Washington Community Action Network, a Transforming Health grantee and HKCC member, worked with stakeholders to establish a Good Food Bag pilot program that subsidizes low-income residents' purchases of healthy foods at the local farmers market.
- HKCC has informed community organizations that had not previously partnered with Children's or PHSKC about Transforming Health; several of them received funding to pursue PSE changes to improve health equity.

As a result of the purposeful community engagement activities of integrating HKCC as a leadership partner and funding community-based organizations, Transforming Health is able to keep a focus on health equity and stay grounded in the needs of the community.

Appendix D - End Notes

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[22]Studies in several sectors suggest that, in the aggregate, approximately half of alliances, consolidations, and partnerships that involve two or more independent organizations coming together do not succeed. However, the evidence indicates the success rate varies in accord with the extent to which these alliances, consolidations, and partnerships incorporate characteristics along the lines outlined in **Appendix A**. Those which adopt and install these features can achieve a success rate of up to 80 percent. For example, see J. Chao, E. Rinaudo, and R. Uhlaner, "Avoiding Blind Spots in Your Next Joint Venture," McKinsey on Finance, Number 48, Autumn 2013, 25-30. http://www.mckinsey.com/search.aspx?q=Avoiding+blind+spots+in+your+next+joint+venture; R. Kaplan, D. Norton, and B. Rugelsjoen, "Managing Alliances with the Balanced Scorecard," Harvard Business Review, Vol. 88, January, 2010, 114-120; Booz & Company, "2013 Payor/Provider/Industry Perspective," December 13, 2012. www.Strategyand.com; R. Foroohar, "Wall Street Values are Calling the Shots," Time, Vol. 184, July 21, 2014, p. 14.

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[24]The rating scale employed by the research team in the third step of assessing the partnerships' nomination for consideration in this study was as follows:

4 = Based on available information, this partnership appears to be exceptionally well-established and highly successful, with clearly-stated goals & objectives and metrics for assessing progress toward them. In addition, this partnership: (a) has provided evidence that its programs and services have had positive impact on the health of the community it serves, and (b) has one or more uncommon features (e.g., its location, the nature of its programs, etc.) that — if this partnership were selected for in-depth study — would bring diversity to the study population.

3 = Based on available information, this partnership appears to be exceptionally well-established and highly successful, with clearly stated goals & objectives and metrics for assessing its progress toward them.

2 = Based on available information, this partnership appears to be well-established and operationally successful in relation to its mission, goals, and objectives.

1 = Based on available information, this partnership appears to meet the baseline specifications we established for partnerships to be eligible for nomination, but the evidence does not suggest that, at this time, it is unusually well-established or successful.

[25]The instructions for members of the research team and National Advisory Committee who participated in the fourth step in the partnership assessment process were:

- **Purpose.** The purpose of [this step] is to identify approximately 15-17 partnerships that appear to be exceptionally well-established, highly successful, and diverse, based on available information. Using the "Core Characteristics and Related indicators of Successful Partnerships" as a guide, please review the information provided on each partnership [and rate them using the following scale]:

  3 = Yes. Based on available information, this partnership appears to be exceptionally well-established and highly successful, with clearly-stated goals & objectives and metrics for assessing progress toward them. In addition, this partnership: (a) has provided evidence that its programs & services have had positive impact on the health of the community it serves or (b) has one or more uncommon features (e.g., its location, the scope of its programs & services, etc.) that — if this partnership were selected for in-depth study — would bring *diversity* to the study population and would definitely be appropriate for a site visit.

  2 = Possibly, would like to discuss. Based on available information, this partnership appears to be exceptionally well-established and highly successful, with clearly stated goals & objectives and metrics for assessing its progress toward them. It may be appropriate for a site visit, but needs further discussion.

  1 = No. Based on available information, this partnership appears to be well-established and operationally successful in relation to its mission, goals, and objectives, but would not be appropriate for a site visit

- **Partnership documentation:** To determine your rating for each partnership, please review the information received on each partnership which is available at [a specified web address]: Each document name includes the same Part 2 ID number and partnership name that appear on the score sheet. For a few of the partnerships, lengthy attachments were limited to only the title page. If you would like to obtain a copy of one of these long documents, please contact Briana Forsythe.
- **Partnership list:** A list of the 30 partnerships, including descriptions, that are included in the Step #3 Screening. After you have completed your ratings, please send your score sheet to Briana Forsythe via email or fax at 859.323.5698. We will contact you next week to organize a conference call to discuss the ratings during the week of February 3rd.

[26]See L. Prybil, R. Peterson, J. Price, S. Levey, D. Kruempel, and P. Brezinski, Governance in High-Performing Organizations: A Comparative Study of Governing Boards in Not-for-Profit Hospitals (Chicago: Health Research and Educational Trust, 2005); L. Prybil, S. Levey, R. Peterson, D. Heinrich, P. Brezinski, G. Zamba, A. Amendola, J. Price, and W. Roach, Governance in High-Performing Community Health Systems (Chicago: Grant Thornton LLP, 2009); and L. Prybil, S. Levey, R. Killian, D. Fardo, R. Chait, D. Bardach, and W. Roach, Governance in Large Nonprofit Health Systems (Lexington, Kentucky: Commonwealth Center for Governance Studies, Inc., 2012).

[27]The local hospital, whose name now is Carolinas Medical Center-NorthEast, continues to be a principal partner and a strong supporter of Healthy Cabarrus. In 2014, Carolinas Medical Canter-NorthEast was the runner-up for the prestigious AHA-McKesson Quest for Quality Award.

[28]For a comprehensive discussion of hospitals serving as "anchor institutions," see D. Zuckerman, Hospitals Building Healthier Communities: Embracing the Anchor Mission (Takoma Park, Maryland: The Democracy Collaborative, 2013).

[29]K. Peisert, Governing the Value Journey: A Profile of Structure, Culture, and Practices of Boards in Transition (San Diego, California: The Governance Institute, 2013), p. 5.

[30]*Ibid*., p. 5.

[31]*Ibid*, p. 5.

[32]See, for example, S. Teutsch and J. Fielding, "Applying Comparative Effectiveness Research to Public and Population Health Initiatives," Health Affairs, Vol. 30, February, 2011, pp. 349-355.

[33]P. Lantz, R. Lichtenstein, and H. Pollack, "Health Policy Approaches to Population Health: The Limits of Medicalization," Health Affairs, Vol. 26, September-October, 2007, p. 1256.

[34]See, for example, M. Porter, "What is Value in Health Care?" New England Journal of Medicine, 363, December 23, 2010, pp. 2477-2481 and Supplementary Appendix 2; Institute of Medicine, Toward Quality Measures for Population Health and Leading Health Indicators (Washington, DC: The National Academies Press, 2013); C. Murray, J. Salomon, C. Mathers, and A. Lopez, Summary Measures of Population Health: Concepts, Ethics, Measurement, and Application (Geneva, Switzerland: World Health Organization, 2002).

[35]Institute of Medicine, Toward Quality Measures for Population Health and Leading Indicators, op. cit, p. 89.

[36]See, for example, K. Kristensen and B. Kijl, "Collaborative Performance: Assessing the ROI of Collaboration," International Journal of e-Collaboration, vol. 6, January-March, 2010, pp. 53-69; and P. Mattessich et al, Collaboration: What Makes It Work (St. Paul, Minnesota: Fieldstone Alliance, 2008).

[37]See for example, "The Second Curve of Population Health," Trustee, Vol. 67, May, 2014, pp. 17-20; and J. Resnick, "Leading the Way to Population Health," Hospitals and Health Networks, Vol. 88, September, 2014, p. 14.

[38]U. S. Centers for Disease Control and Prevention. Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants (Atlanta, GA: Office of Surveillance, Epidemiology, and Laboratory Services, 2013).

[39]See, for example, C. Murray and A. Lopez, "Measuring the Global Burden of Disease," New England Journal of Medicine, Vol. 369, August 1, 2013, pp. 448-457.

[40]Nonprofit hospitals in the USA traditionally have devoted a large majority of their community benefit spending to pay for services provided to uninsured or underinsured patients. Meeting these obligations will continue to be a major burden for our nation's hospitals for the foreseeable future, however, allocating community benefit funds to support multi-sector partnerships focused on addressing high-priority health needs and improving community health is highly consistent with provisions of the Patient Protection and Affordable Care Act. For information about the historical provision of community benefits by nonprofit hospitals and emerging opportunities for these institutions to participate in evidence-based prevention and community health improvement initiatives, see G. Young, et al, "Provision of Community Benefits by Tax-Exempt U.S. Hospitals, New England Journal of Medicine, Vol. 368, April 18, 2013, pp. 1519-1527; Trust for America's Health, Nonprofit Hospitals to Maximize Community Benefit Programs Impact on Prevention (Washington, DC: Trust for America's Health, January, 2013); and S. Johnson, "Diagnosing a Community's Health Needs: Not-For-Profit Hospitals Target Health Improvement Efforts Under Reform Law," Modern Healthcare, Vol. 44, June 16, 2014, pp. 14-16.

[41]N. Adler, C. Bachrach, D. Daley, and M. Frisco, Building the Science for a Population Health Movement (Washington, DC: National Academy of Sciences, December 2, 2013), p. 3.

[42]See, for example, R. Tio, "Moving Toward Population Health," Hospital and Health Networks, Vol. 88, May, 2014, p. 14; and A. Garcia, A. Pomykala, and S. Siegel, "U. S. Health Care is Moving Upstream," Health Progress, Vol. 94, January-February, 2013, pp. 7-13.

[43]See, for example, D. Nygren, "Competitors as Collaborators," Trustee, Vol. 66, September, 2013, pp. 13-27; and M. Brainerd, J. Campbell, and R. Davis, "Doing Well By Doing Good," McKinsey Quarterly. September, 2013. http://www.mckinsey.com/insights/social_sector/doing_well_by_doing_good_a_leaders_guide

[44]Building the Science for a Population Health Movement, op. cit., pp. 4-6; and Stoto, op. cit., pp. 2-5.

[45]National Quality Forum, Multistakeholder Input on a National Priority: Improving Populational Health by Working with Communities: Action Guide 1.0 (Washington, DC: National Quality Forum, August 1, 2014), pp. 26-27.

[46]L. Spears, "Tracing the Growing Impact of Servant-Leadership," in L. Spears, Editor, Insights on Leadership: Service, Stewardship, Spirit, and Servant Leadership (New York: John Wiley and Sons, Inc., 1998), p. 1.

[47]For information regarding ten states that have established requirements for nonprofit hospitals regarding *implementation strategies to address community needs*, see G. Nelson, et al, "Hospital Community Benefits After the ACA: Addressing Social and Economic Factors that Shape Health" (Baltimore, Maryland: The Hilltop Institute, May, 2014).

[48]For useful information regarding collaborative approaches to improving population health by incorporating health considerations in governmental (and private sector) decision-making processes, see L. Rudolf and J. Caplan, Health In All Policies: A Guide to State and Local Governments (Oakland, California: Public Health Institute, 2014).

[49]Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants, op. cit., p. 1.

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