AREA OF FOCUS
Advancing Health Equity →

NEWSLETTER ARTICLE /

Improving Population Health Through Communitywide Partnerships

Summary: *Community health partnerships that bring clinicians together with civic groups, social service providers, and educational leaders among many others are proving to be an effective means of improving population health. Among their benefits, the partnerships help communities prioritize health needs and streamline resources to address them.*

By Martha Hostetter and Sarah Klein

Many quality improvement techniques—including the promotion of evidence-based treatments and well-coordinated care—can improve health outcomes, but their influence is often limited by factors beyond clinicians' control, such as patients' education, employment, and social support.[1] To address the social and economic factors that affect health, quality improvement initiatives must reach beyond the traditional boundaries of the health care system. One promising approach is the use of community-based partnerships that bring a wide range of stakeholders—health care providers, educators, business leaders, social service providers, community organizations, and clergy—together to promote healthy behavior, improve access to primary and preventive care, and reduce health disparities.

Models of Community Engagement

In northeast Wisconsin for example, the ThedaCare health system, comprised of five hospitals and 22 physician clinics, launched a Community Health Action Team (CHAT) that the local education system, government, businesses, clergy, and nonprofit organizations, as well as clinicians, in identifying community health issues. The 25-member group then takes part in "plunge" events designed to hear from affected residents as well as caregivers on the frontlines.

One CHAT program, the Shawano County Rural Health Initiative, arose from the team's realization that many local farming families were uninsured or had inadequate coverage, and often skipped check-ups or treatment for chronic conditions. Many of these families

also faced economic hardships and felt disconnected from their communities. Over the past eight years, rural health coordinators have visited more than 325 farms—40 percent of all of the farms in Shawano County—to provide health information, perform screenings, and connect residents to needed health and social services.[2] The coordinators are all registered nurses who receive training to do this work; two are paid by the Rural Health Initiative and one works for the region's public health department. Their outreach to farming families has resulted in the identification of more than 225 people in need of acute care, including residents at risk for suicide and those with untreated melanoma, severe hypertension, and diabetes. The coordinators have also made 568 referrals for health concerns and nearly twice that many for non-health services such as financial counseling or other social services.

According to Rhonda Strebel, M.B.A., executive director of the initiative, this approach has been effective because it takes health—or what she describes as "kitchen wellness"— to people's homes and because she and other coordinators have rural backgrounds that help them understand farmers' needs.

"The plunges get at the foundational layer of what creates health," says Paula Morgen, ThedaCare's manager of community involvement. "Afterward, everybody on the team has learned the same things at same time, and they feel ownership of the issue." In addition to the Rural Health Initiative, plunge events have led to efforts to improve transportation services for seniors, expand adult literacy education, and raise awareness of poverty. Most of the funds for the CHAT programs come from ThedaCare, which provides money from a percentage of its profits each year.

In Ohio, clinicians at Cincinnati Children's Hospital Medical Center are encouraged to look beyond the traditional ways of treating medical conditions to consider the upstream factors —such as poverty and nutrition—that affect children's health. In one example, pediatricians used funding from the National Institutes for Health to pinpoint where children with asthma live. The process known as “geocoding” helped highlight the importance of factors such as housing—not just drug treatments—in children's health. It also made it clear that the hospital needed community partners. One such partnership with the Legal Aid Society of Greater Cincinnati revealed that 16 children with asthma lived in housing owned by the same developer, who had allowed the apartments to become squalid. Legal Aid helped the tenants form an association to demand repairs.

The hospital is now expanding this approach to other conditions. "Our Population Health team is now geocoding all emergency department visits and admissions for childhood injury by age group and mechanism," says Robert Kahn, M.D., M.P.H., associate professor of pediatrics at the University of Cincinnati College of Medicine and Cincinnati Children's Hospital Medical Center. "We can then go back to the community to share this information

with the police and fire departments, EMS, as well as the town council and mayor to brainstorm about ways to improve child safety."[3]

In Windsor, Vt., Mt. Ascutney Hospital and Health Center has had nearly two decades' of experience in a community-based approach to improve senior housing, prevent substance abuse, and connect residents to social services. Its efforts were recognized with the 2011 Foster G. McGaw Prize for Excellence in Community Service, awarded by the American Hospital Association and the Baxter Allegiance Foundation.

Mt. Ascutney has made it a priority to track the outcomes of this work, though this is difficult given the fact that changes in community health may not become apparent for years. Nonetheless, it has been able to show measureable improvement from its decade-long partnership with local schools to educate high school kids about the risks of substance abuse and tobacco use—an issue identified in a community needs assessment. Over 2001 to 2011, Windsor youth reported greater-than-average decreases in alcohol, tobacco, and marijuana use, compared with the state average: a 13 percentage-point reduction in alcohol consumption among Windsor eighth graders, compared with a 10 percentage-point reduction statewide; a 16 percentage-point reduction in smoking, compared with a 10 percentage-point reduction statewide; and an 11 percentage-point reduction in marijuana use, compared with a 2 percentage-point reduction statewide.

In South Carolina, the Healthy Columbia initiative, which focuses on the region in the zip code 29203, relies on the principles of community organizing to increase access to care and reduce rates of chronic disease, emergency department utilization, and hospitalization. The program relies primarily on volunteers to implement screening programs for blood pressure and diabetes, provide peer-to-peer health coaching, and build community gardens where vegetables are in short supply. The program's 200 volunteers—drawn from local churches, civic organizations, local fraternities and sororities, and health care organizations—have been trained in community organizing and are expected to recruit more volunteers, says Laura Long, M.D., M.P.H., a founding member of the group and vice president of clinical quality and health management for BlueCross BlueShield of South Carolina.[4]

In some locations, community groups receive guidance from the Institute for Healthcare Improvement's Triple Aim initiative, which is designed to help them identify unmet health needs (see Q&A). In Pueblo, Colo., the IHI program helped identify the importance of increasing access to primary care, improving chronic disease management, and developing more regional health promotion programs, says Donald Moore, M.H.A., CEO of Pueblo Community Health Center.

"What really resonated with the community was engaging patients in their responsibility for health and use of health care. We are framing the whole discussion of chronic disease management and ER usage in that patient responsibility framework. Without activating patients to do more for their own health, clinics, hospitals and health care providers, alone, won't be successful with our Triple Aim effort." Moore says.

Even the Best Can Do Better

Even communities with good health outcomes are working to do better. In both 2010 and 2011, Collier County was ranked the healthiest in Florida out of 67 counties on CountyHealthRankings.org, a benchmarking site created by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. "We were a bit surprised the first year we were anointed healthiest county," says Allen Weiss, M.D., president and CEO of the NCH Healthcare System, based in Naples. "We got together to talk about it—we had 100 different agencies in the room, representatives from public health, the YMCA, schools, fire department, and others. Rather than working at what we are already good at—low mortality rates, low door-to-balloon time, infant birth weight—we said, let's look at what we don't do well, and form mini taskforces to come back with an executable plan—one idea of something we can do to try to address it."

Among other efforts, the group is focusing on lowering childhood obesity rates, targeting their efforts to one zip code where three public elementary schools have obesity rates topping 25 percent. Todd Vedder, M.D., NCH's chair of pediatrics, is leading efforts to engage parents, increase kids' caloric burn during play periods, increase kids' opportunities to take part in fitness activities and choose healthy foods, and increase the number of mothers who exclusively breastfeed their babies at two, four, and six months.

Sustaining the Work

For community health improvement efforts to succeed, many say, it is important to keep momentum going on collaborative efforts, especially when team members come and go, and no one person feels ownership of the work. Morgen of ThedaCare recalls that its initial effort to improve health beyond its clinics—aimed at getting women screened for breast cancer—fizzled out because it relied on a flawed approach. "We started with the medical model: we picked health experts, and then reached out to hair salons to enlist stylists in educating women," she says. "It had an impact, but it wasn't sustainable because it relied solely on us to keep it going." After going through a "Creating Healthy Communities" fellowship program from the American Hospital Association, Morgen helped to develop the CHAT model of community engagement, in which ThedaCare acts more as a facilitator than a leader of projects.[5] "Our doctors and nurses absolutely should have a seat at the

table, but they shouldn't be the only ones driving solutions," she says.

The NCH health system began with what Weiss describes as "small, doable" projects but then gave legs to these efforts by lending its community partners the infrastructure and staff resources to raise funds and spin off an independent nonprofit, the Safe and Health Children's Coalition of Collier County, that focuses on reducing SIDS, childhood obesity, and drowning (the number-one cause of death among preschool children in Florida).

"Not only does [the hospital] need to be the guiding force, you have to be willing to take on risk and responsibility," says Mt. Ascutney's Donovan. "We have served as fiscal agent for the majority of grants that come into community; we are financial incubator for many programs."

Sorting out what to do with the savings and developing equitable ways of reinvesting it to sustain the programs may be more complicated. “Is the negotiation with the hospital where the cost savings and utilization changes are occurring or is it with the insurers who are paying less than they otherwise might have? How do you structure those relationships? None of us in the field know exactly how to do that,” Milstein says.

Still, there’s cause for optimism. New payment models, which focus on prevention and wellness, rather than acute care, and on bundled or per capita payments for populations, are likely to lead to a redefinition of institutional roles in health care. "The era of inpatient growth is over," says Weiss. "Hospitals have to get into the prevention business: everyone benefits when we work towards keeping people healthy."

John O'Brien, president and CEO of UMass Memorial Health Care, Inc., and chair of the Foster G. McGaw Prize Committee, says that efforts to improve community health may not have immediate returns, but in the dawning era of capitated payments such programs are likely to pay off: "This is a business issue—this isn't altruism. Community benefit is good business."

Resources for Community Health Improvement

Health Improvement Health care providers' efforts to reach beyond their walls to improve community health are prompted in part by new federal regulations that encourage local coordination and fostered by the availability of benchmarking tools and technical assistance programs. These include:

Simulation/Planning: The Fannie E. Rippel Foundation's ReThink Health program has made available a regional health planning tool that enables stakeholders to use the techniques of simulation modeling and game-based learning to forecast the costs and benefits of various interventions (such as improving preventive health, reducing crime, and enhancing care for chronic mental illness) and to make decisions about how and where to invest resources. The model might indicate that "if you are really trying to deliver value to the insurers, you might need reduce costs still further than you could accomplish just with readmissions alone or just with outpatient stuff and the ER," says Bobby Milstein, Ph.D., M.P.H., director of the Rippel Foundation's ReThink Health Dynamics program. "A lot of this is about setting realistic expectations and then not getting comfortable with the mediocre improvement," he says.

Federal funds: There has been significant funding from the federal government to increase wellness through community-based programs that aim to reduce health care costs by preventing disease in the first place. For example, the Centers for Disease Control and Prevention is supporting 149 ACHIEVE communities in their efforts to reduce tobacco use and exposure, promote physical activity and healthy eating, and improve access to preventive health services.

Measurement: The forthcoming *Scorecard on U.S. Local Health System Performance, 2012*, from The Commonwealth Fund's Commission on a High Performance Health System compares 306 hospital referral regions on several indicators of health care access, quality, health outcomes, and utilization/costs. This information can help partners identify community assets and target areas where they lag behind regional, state, and national benchmarks. In addition, the Centers for Medicare and Medicaid Services recently made its extensive Medicare claims database—including information on individual providers—available to certain types of community groups for the purposes of performance benchmarking and reporting efforts, as part of a provision of the Affordable Care Act. WhyNotTheBest.org, The Commonwealth Fund's benchmarking and quality improvement site, enables explorations of regional performance on several measures of health care quality, outcomes, and population health. Finally, communities developing regional health information exchanges will have significant advantages in using health care data to study and improve population

health.

Improvement Initiatives: As part of its Aligning Forces for Quality work, the Robert Wood Johnson Foundation has provided funding and technical assistance to 16 geographic regions that have brought stakeholders together to reduce fragmentation, improve quality of care, and measure and publicly report performance, among other goals.

Community Health Assessments: The Affordable Care Act requires nonprofit hospitals to perform community needs assessments by gathering input from individuals across the community, including those with public heath expertise, and describing how the hospital plans to implement programs to address the identified needs. The Association for Community Health Improvement offers a Community Health Assessment Toolkit to help hospitals understand and improve the health of residents in their communities.

---

[1] According to a widely cited model from the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, population health is determined by several different factors—with access to and the quality of clinical care accounting for just 20 percent. Health behaviors (such as tobacco use and diet) account for 30 percent, while the physical environment accounts for 10 percent. According to the model, fully 40 percent of population health relates to social and economic factors such as education, employment, income, safety, and social support. Also see J. M. McGinnis, P. Williams-Russo, and J. R. Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs*, March 2002 21(2):78–93.

[2] While the initiative cannot pay for the services to which patients are referred, they work with health care providers to facilitate affordable access. The goal of the program is to provide access to preventive and timely care and to help people avoid costly conditions. Generally, the CHAT teams fund no more than half of the start-up costs of projects.

[3] For more information about how to create medical-legal partnerships, see http://www.ihi.org/knowledge/Pages/AudioandVideo/WIHIRemovingBarrierstoCareMedicalLegalPartnerships.aspx.

[4] For more information, see http://www.ihi.org/knowledge/Pages/AudioandVideo/WIHIOrganizingforHealthSouthCarolina.aspx.

[5] This fellowship program evolved into the Association for Community Health Improvement, http://www.communityhlth.org/, which offers education, tools, and other resources for hospitals to measure and improve community health.

PUBLICATION DETAILS

AREA OF FOCUS

Advancing Health Equity