ASTHO*Report*
In-depth coverage of leading state and territorial public health issues.

January 2020

Collaborations Between Health Systems and Community-Based Organizations

EXECUTIVE SUMMARY

Across the nation, healthcare delivery systems and community-based organizations (CBOs) are developing partnerships to address the social determinants of health and behavioral health needs of their attributed or geographic populations. In 2018, the Association of State and Territorial Health Officials (ASTHO) conducted an environmental scan of all 50 states and the District of Columbia and identified 141 partnerships between healthcare delivery systems and CBOs aimed at improving behavioral health outcomes. ASTHO then interviewed four health systems to better understand why they partnered with CBOs and to define essential elements of effective partnerships. According to the interviewees:

- Partnerships with CBOs can connect healthcare delivery systems with experts on the social determinants of health and increase clinicians' ability to address the nonmedical issues that affect a patient's health.
- Community partnerships allow health systems to create connections with under-resourced populations who may not be engaged with the health system.
- Partnerships that pool resources and staffing can be cost-effective and increase access to health and social services. In addition, strong partnerships that pool and blend resources and staffing may achieve a greater impact.
- Creating a successful partnership requires a common vision and sense of trust, along with a commitment to setting aside dedicated staff time and attention to building the relationship before entering into the project together.
- Sharing information and data requires frequent meetings of health systems and their partners and creating communication strategies, such as digital platforms, are essential to share information and data.

This report illustrates strategies for overcoming early challenges to developing a new partnership. These strategies ensure that CBOs and community voices are valued in decision-making and priority-setting.

TABLE OF CONTENTS

INTRODUCTION

A community's social and built environments, discriminatory practices, educational opportunities, and economic stability all contribute to an individual's health status and overall wellbeing. Healthcare delivery systems recognize the effect of these social determinants of health on health outcomes, and are partnering with community-based organizations (CBOs) to deliver social services that improve health-related social and behavioral health needs in their communities. These services include supporting home visits by community health workers, co-locating healthcare and social services, providing housing, and supporting care coordination among high healthcare-utilizing populations. This report highlights four health system-CBO partnerships and discusses common themes and lessons learned that other health systems can apply in their own communities.

CASE EXAMPLE 1: Kent County's Strong Beginnings Partnership

Strong Beginnings is a community partnership dedicated to improving the health and well-being of African American and Hispanic or Latino families in Kent County, Michigan. Strong Beginnings works at two levels to improve racial health disparities: Providing direct services to clients and effecting systems-level change.

The rate of infant mortality in Kent County is two to four times higher among black infants than white infants, which mirrors similar rates across the United States. The Kent County Health Department assembled a group of 12-15 volunteers from various healthcare agencies to form an Infant Health Action Team (IHAT) whose members conducted extensive research, held town hall meetings, conducted key informant interviews, and collected surveys to obtain community input and identify potential solutions. The community identified systemic racism in healthcare facilities and other societal influences as the underlying cause of the health disparities.

The IHAT team launched the Strong Beginnings partnership as series of activities to (1) improve access to services that address social determinants of health, (2) reduce unplanned pregnancy, and (3) dismantle racism. The IHAT members then convened the hospitals and major healthcare agencies in Kent County to collectively apply for federal Healthy Start funding, which was granted in 2004. Spectrum Health became the fiduciary for Strong Beginnings partnership. Additional funding from the W. K. Kellogg Foundation in 2011 and 2014 allowed Strong Beginnings to expand to all of Kent County, add a fatherhood component, and address needs of the Hispanic or Latino population in Kent County.

How Does It Work?
Spectrum Health and partner agencies provide home visits by teams of community health workers, nurses, social workers, and mental health therapists for women and their partners during pregnancy and 18 months after delivery. The services address physical health, mental health, social needs, and parent engagement. Strong Beginnings now serves approximately 950 families per year. An additional 3,000 individuals benefit from community education, workshops, weekly breastfeeding support groups, parenting classes, and anti-racism efforts each year. The program is data-driven and community-centered, with strong community and client representation. Many of the program's clients serve on IHAT (which has grown to 90 members) to help create and guide programmatic decisions.

To effect system-level change, IHAT has 12 committees related to social determinants of health that are referred to as the Strong Beginnings Community Action Network. The committees are centered around a common goal to achieve community-level change that improves the overall system of care and promotes racial equity. Committee members include social service and healthcare providers, program participants, businesses, community residents, and government officials. Strong Beginnings also participates in state and national collaboratives to effect policies and social determinants that impact maternal, paternal, and child health.

Partners

As a federally funded Healthy Start program, Strong Beginnings brought together a diverse set of partners from hospital systems, mental health sectors, federally qualified health centers, CBOs, and local public health agencies. The Kent County Health Department, Cherry Health federally qualified health center, and the three hospital systems—Spectrum Health, Mercy Health, and Metro Health—provide home visits and care coordination for enrolled women and their children. Arbor Circle, a mental health facility, offers behavioral and mental health counseling, the African American Health Institute houses the fatherhood initiative, and Michigan State University and Changing River consultancy are the program's external evaluators. Spectrum Health serves as the program's fiduciary and grants manager.

> *"It is unusual to have three hospital systems that are normally competitors come together to address a common goal. They were able to set aside turf wars to work on this community problem of infant mortality."* —*Strong Beginnings interviewee*
>
> *"We've been working on social determinants of health long before that became a buzzword."*—*Strong Beginnings interviewee*

Outcomes

A three-year [evaluation](#) showed that, compared to other African American pregnant women receiving Medicaid in Kent County, Strong Beginnings clients are statistically more likely to be in extreme poverty, be unmarried, have an unplanned pregnancy, have a clinical diagnosis of depression, use drugs or tobacco, have a prior poor pregnancy outcome, experience homelessness, and be in abusive relationships. However, Strong Beginnings clients were also more likely to receive adequate prenatal and postpartum exams and complete all well-child visits, as shown below:

- The evaluation showed a 21 percent lower prevalence of preterm births for Strong Beginnings participants, with a potential yearly savings of at least $855,000 in state Medicaid medical costs alone during the first year of life.
- Between 2005 and 2018, the rolling infant mortality rate for Strong Beginnings participants was 5.3 infant deaths per 1,000 live births, compared to the total African American rate of 10.4-19.4 infant deaths per 1,000 live births in Kent County.
- Strong Beginnings clients had a 50 percent increase in breastfeeding rates compared to women who were not in the program.
- Women who received mental health services through the program attained a 25 percent reduction in depression scores. In addition, 92 percent of pregnant women in the program stayed clean and sober until delivery, and 90 percent met substance misuse treatment goals.

Because of the program's positive outcomes, Strong Beginnings received a five-year Pay-for-Success (PFS) contract from the state of Michigan. PFS is a mechanism for governmental investors to provide up-

front capital for projects that achieve a social good and have the potential for demonstrating cost savings. This is the first PFS project in Michigan, and stakeholders anticipate that PFS has the potential to provide long-term sustainable funding to Strong Beginnings if the program continues to demonstrate lowered rates of preterm birth and rapid repeat pregnancy.

Lessons Learned

According to the interviewees, health systems and CBOs must commit to a common goal early in the partnership development process to establish a strong foundation that allows the team to quickly respond to funding opportunities. In addition, the partnership should include community members who are impacted by the program in the planning and design process to ensure strong community engagement throughout the program period. Finally, partnerships that evaluate and address the underlying systemic and societal factors of poor health (e.g., institutional racism, inadequate transportation systems, under-resourced education systems, and lack of access to clinical care) will more effectively reduce disparities in health outcomes.

CASE EXAMPLE 2: Connecticut Children's Medical Center Care Coordination Collaborative

In 2010, the Connecticut Children's Medical Center established a regional care coordination collaborative to build cross-sector partnerships that support children and families. Initially, the collaborative focused on children and youth with special healthcare needs, such as chronic and complex medical or developmental conditions. However, shortly after the mass shooting at Sandy Hook Elementary School in 2012, the Connecticut Children's Medical Center witnessed an influx of children needing behavioral and mental health support and immediately increased its capacity to provide expanded services to children and families. The collaborative quickly followed suit and invited behavioral health CBOs and agencies to the table. The Connecticut Children's North Central Care Coordination Collaborative has now become the Connecticut Department of Public Health's regional model to address the needs of all children in the state, with statewide replication funded by the Connecticut Department of Public Health and the Connecticut Health Foundation.

How Does It Work?

The North Center Care Coordination Collaborative is a community-based model that aims to reduce duplicative care coordination efforts and ensure that children and families have access to the critical services they need. The collaborative model endorses universal psychosocial, behavioral, and medical assessment for children and works with families to develop a shared plan of care by providing linkages to medical, behavioral, and social services.

The North Center Care Coordination Collaborative staff meet with care coordinators from a variety of child serving sectors to provide trainings about available services that children and families can access, collectively review challenging cases and develop cross-sector solutions, develop and advocate for policy-level solutions, and support pediatric primary care to meet the needs of children and families by reducing duplication and streamlining services. The collaborative uses the Strengthening Families Protective Factors framework to build family resilience and provide education and tools to improve parenting skills, provide concrete support for families, and increase children's social and emotional confidence.

Partners

The collaborative received funding from the Connecticut Department of Public Health to partner with social workers, community care coordinators, physicians, and pediatric nurses to provide medical and social services. The collaborative partners with other state agencies and organizations, including Connecticut's Department of Children and Family Services, Department of Social Services, Department of Developmental Disabilities, Department of Early Childhood Education, and Office of the Child Advocate; local CBOs; behavioral health agencies, United Way 211, and the Child Development Infoline resource directory. The North Center Care Coordination Collaborative also sits on the board for several regional collaboratives in the state to remain informed on local care coordinating initiatives. The North Center Care Coordination Collaborative provides technical assistance to four other regions and holds regular meetings for care coordinators in child-serving sectors to discuss challenges and break down silos.

Outcomes

The North Center Care Coordination Collaborative has screened over 9,600 children for behavioral, developmental, and medical conditions and provided direct care to over 50 percent of these children. According to interviewees, the collaborative has also improved staff knowledge within Connecticut Children's Medical Center about available community resources for children and families. Through the regular care coordinator meetings, participants have built relationships with new partner organizations, connected patients to additional resources (e.g., domestic violence resources and homeless shelters), and secured funding for suicide prevention programming.

> "*Even though our funding is specifically to support children, you can't separate children from families. So, we like to bring other people to the table so that if we're working with a family with domestic violence, we can support that parent and give them information that could help them.*" —Connecticut Children's Medical Center interviewee

Lessons Learned

The collaborative conducts an annual environmental scan to assess the landscape of current partners and identify additional expertise to bring to the table. The interviewees identified this annual scan as a useful practice to recognize statewide gaps in care and available resources. The collaborative has established easily accessible and centralized platforms for partners to report care plans and conduct other care coordination activities. Lastly, the collaborative identified the Strengthening Families and Protective Factors framework as an essential resource for providers and care coordinators to learn how to build family resilience, support social connection, and enhance the provision of family-centered care coordination.

CASE EXAMPLE 3: The Better Health through Housing Partnership

The Better Health through Housing program is a partnership between the University of Illinois Hospital and the nonprofit Center for Housing and Health aimed at reducing healthcare costs and improving the health of chronically homeless individuals by providing them with stable housing. Aided by an initial $250,000 in funding from the hospital, the pilot program launched in 2015.

How Does It Work?

The Better Health through Housing program identifies individuals from a hospital-provided list of patients who are high emergency room utilizers experiencing chronic homelessness. A multidisciplinary

panel reviews the patient cases, and those accepted are referred to an outreach worker who visits encampments to locate the patients. Patients who accept housing are moved to a single room occupancy hotel and assigned a housing case manager to help them find permanent supportive housing. The program referred its first patient in November 2015 and receives ongoing support from hospital leadership, with total investment to date of $539,000. The hospital pays $1,000 per member per month to the Center for Housing and Health and has now housed 59 homeless individuals.

Partners

The program benefits from numerous cross-agency partnerships. The Center for Housing and Health has a memorandum of understanding with 27 supportive housing agencies with scattered units throughout the city, which has been valuable for identifying potential program residences. The agency also has contracts with single room occupancy hotels and a large mental health agency (Heartland Health), which provides the outreach worker. Other housing agencies involved in this partnership include Corporation for Supportive Housing, Illinois Public Health Institute, City of Chicago Department of Public Health, City of Chicago Health and Human Services, jails, and police and fire departments.

The Center for Housing and Health has added innovative financing to the program by creating the Flexible Housing Pool, modeled off a program in Los Angeles. This funding pool brings together many different services that this population needs by aggregating disparate funding sources into a common pool. Other hospitals and government agencies have been involved in contributing to the pool, which aims to create collective impact and capacity to create 750 new affordable housing units. Better Health through Housing is developing an evaluation to assess progress made since the program's inception.

> *"This partnership creates a one-stop-shop and reduces the need for clearances with several agencies. It demonstrates that housing is health, and not having a place to live is detrimental to one's health due to injuries one suffers by not having housing."* —Better Health through Housing interviewee

Outcomes

The program has seen significant reductions in emergency room utilization and healthcare costs since its launch in 2015. Overall emergency room utilization has fallen by 57 percent, with a 67 percent drop in utilization for inpatient admission, and the program also saw a 21 percent reduction in healthcare-associated costs. Better Health through Housing has also demonstrated that homelessness carries significant health risks, reporting a 24 percent mortality rate.

> *"This is a partnership, and one needs to be open to changes and to a learning collaborative. Don't keep this to strict contracting rules or it will fail. The model is adaptive and needs to be modified."* —Better Health through Housing interviewee

Lessons Learned

Interviewees commented on the importance of involving as many partners as possible in the collaboration to both expand the program's reach and provide clients with a range of options in terms of preferred neighborhoods. According to interviewees, hospitals should consider partnering with agencies that are willing to replicate the Center for Health and Housing model or other successful models. Program leads also highlighted the need to keep the program structure fluid and flexible to accommodate the target population's changing needs.

CASE EXAMPLE 4: Fillmore County Hospital's Partnership with Public Schools

In response to an uptick in diagnosable mental health conditions among school-age patients, the Fillmore County Hospital in Nebraska initiated a partnership in 2015 with Fillmore Central Public Schools. Building on Fillmore County Hospital's existing integrated approach for behavioral health, the partners developed a referral program to help students receive the appropriate care for their behavioral health issues.

How Does It Work?

Fillmore County Hospital and Fillmore Central Public Schools formalized a committee to advise the program's implementation and design. The program identifies students with high-risk behavioral health issues and refers them to a hospital therapist, who conducts one-on-one sessions with the students in the school setting during the school day. The hospital covers the salary of this part-time therapist, who currently works with 12 students.

The therapist also has expanded duties, such as holding office hours with teachers and performing classroom observations. To increase mental health awareness, students receive training on conflict resolution, self-care, adverse childhood experiences, and youth mental health first aid. Furthermore, Fillmore Central Public Schools has added a mental health module that has been added to the school health curriculum, which includes morning mindfulness exercises. The program also provides an evidence-based training for parents to help them learn proactive strategies to address their child's behavioral problems.

Partners

The partnership includes leadership from Fillmore County Hospital and Fillmore Central Public Schools, including principals from elementary, middle, and high schools as well as school superintendents. The hospital CEO and the behavioral health director were actively involved in leading and facilitating the program. Partnership meetings occur quarterly to discuss program updates, progress, and challenges.

Outcomes

Fillmore Central Public Schools have reported improvements in behavioral health outcomes, academic scores, and school attendance among the 12 participating students. The program also saw improvements in parental collaboration with schools and an increased number of student-reported abuse experiences. According to interviewees, the partnership is a mutually beneficial arrangement for both entities, since the schools could not afford to hire a therapist on their own and the hospital was able to expand access to care and screenings.

> "The model was unique and built from the ground up. In order to keep the partnership strong, the most important factor was communication." —Fillmore County Hospital Interviewee

> "Identify what each entity is good at and let them excel in those pieces. This model was sustainable because the therapist was merged in both the hospital and school, creating more work for the therapist" —Fillmore County Hospital Interviewee

Lessons Learned

According to the interviewees, early in the development of partnerships, it is essential to define the role of each partner, identify the resources they can offer, and understand one another's challenges and motivations. Ongoing planning and relationship-building among partners requires consistent and clear communication to track progress and address any arising issues.

Interviewees also noted that, because every community is distinct, it is vital for partners to adapt to shifting circumstances and needs. An ongoing challenge is securing sustainable funding sources to ensure program continuity.

DISCUSSION: Why Partner with Community Based Organizations?

Community-based partnerships can benefit health systems by building expertise on the social determinants of health and health-related social needs of their patients, building trusting relationships with underserved populations, and pooling knowledge and resources.

Driver of Social Determinants of Health Work

According to interviewees, partnerships with CBOs offer health systems a closer look into the non-medical issues impacting a community's health. Engaging community members in sharing their lived experiences increases the health systems' awareness of the most critical equity issues impacting the community's health. For example, the Strong Beginnings partnership held discussion workshops for its staff and service providers on racism and implicit bias to help them to apply a "racial equity lens" to their work. The program hosts similar engagement activities and discussions with community leaders.

Capacity to Reach Under-Resourced Communities and Build New Connections

Community partnerships allow health systems to create connections with under-resourced populations who may not typically engage with the health system. CBOs are deeply rooted in their communities and can assist hospitals in making care more accessible. For example, in rural Fillmore County, Nebraska, interviewees noted that school officials were struggling to engage students with behavioral health issues, and the partnership with Filmore County Hospital has allowed them to develop linkages to care and expand access to preventive services. Interviewees also noted that teachers have been able to adopt strategies from the hospital staff on ways to communicate with and educate students on self-care.

Ability to Pool Knowledge and Resources

Partnerships between health systems and CBOs allow organizations to pool financial and staffing resources, which may be a cost-effective way to strengthen the care continuum. Interviewees also noted that partnerships further other innovative ways of building community health. The Better Health through Housing partnership led to the creation of the Flexible Housing Pool, which aggregates disparate funding sources into a common pool of funds to create housing units that provide supportive services. Clients in the program are assisted by case managers to improve their financial wellness, coordinate medical appointments, and receive referrals to other social services. In addition, Connecticut Children's Medical Center staff have indicated that they have benefited from their care coordination collaborative model because the regular meetings and annual environmental scan increase their awareness of existing services and potential partners in the state.

WHERE TO BEGIN: What Key Elements Make Partnerships Effective?

Interviewees identified the importance of deliberately committing staff time and effort in the early phases of partnership development. Interviewees recommended setting a strong foundation by building relationships, trust, and understanding among partnering organizations and sectors. This can include discussions to learn about one another's priorities, operational realities, and biggest challenges.

Allocating time to set common goals in the early phases can also help ensure that efforts are coordinated and aligned. Through this trusting relationship—and potential "early wins" that address common goals—partners can then move toward more intensive partnership activities, such activities that involve braided financing (in which each partner contributes dollars that serve a distinct purpose in support of a broader, coordinated purpose) or a blending funds in a shared pool.

Interviewees noted that structuring the programs in a learning collaborative format can also build a platform to bring new partners to the table and create an environment where they can learn from each other as they work together towards a common goal. The Better Health through Housing program described its work as a learning system as opposed to creating a vendor-type relationship among partners. The Connecticut Children's Medical Center also brings partners together in a shared learning format, which allows different organizations to strategize, be aware of one another's efforts, and avoid duplication of efforts.

> **Considerations for Partnerships:**
>
> **Start *somewhere*:** Find a small "win" that partners can work on together to build a relationship.
>
> **Research**: Learn about your partners' priorities, assets, and challenges.
>
> **Engage the local community in all phases of partnership development**: Effective partnerships consult, collaborate with, and share leadership with communities.
>
> **Bring the right people to the table (and find ways to keep them there):** Continually assess and reassess if new partners should be involved. Meet and communicate often so partners stay engaged.
>
> **Learn from other examples in the field:** Look for successful models available to replicate.

Cross-sector partnerships must also consider the role of data to track and evaluate the progress of the collectively set objectives. Therefore, shared data platforms may enable partners to better communicate. However, technological barriers were noted by some of the interviewees as factors hindering real time use of shared data. Interviewees highlighted the significance of prioritizing the creation of continuous communication channels early in the process of partnership development.

Interviewees noted that meaningful community engagement ought to serve as a driving force and an integral piece of the partnerships, as community members and CBOs are best positioned to identify barriers to access to health and healthcare, set priorities, and identify contextually and culturally appropriate solutions. Interviewees also stressed the need to not only engage with community members and CBOs in an advisory capacity through outreach efforts but to also integrate them into the collaborative process and decision-making structure.

Finally, as the selected case studies illustrate, variations in public health systems across states and communities can affect the scope of public health involvement. For example, most of the interviewees worked with both state and local public health agencies, but Fillmore County Hospital worked with a public health foundation. Rurality or state public health structures may play a role in shaping which public health entities are best positioned to collaborate. Nevertheless, state and local public health agencies are valuable partners due to their ability to provide data, fund initiatives, convene cross-sector stakeholders, and offer expertise in community engagement.

Health systems are embarking widely in partnerships with CBOs, and those interested in initiating partnerships can benefit from the experiences of existing collaborations. The partnerships identified in

this report not only highlight opportunities for collaboration but also illustrate the value of working with communities in order to improve physical and behavioral health outcomes.

APPENDIX: RELATED RESOURCES

Strong Beginnings Partnership:

- *Grand Rapids Business Journal* article: "Strong Beginnings to pilot pay-for-success model"
- Harvard Kennedy School Government Performance Lab web page: "Strong Beginnings Pay for Success"
- HRSA web page: "Healthy Start"
- HHS Office of Minority Health web page: "Infant Mortality and African Americans"
- Spectrum Health press release: "New Support Expands Reach of Strong Beginnings Women and Children's Health Initiative"
- Strong Beginnings web page: "About Us"

Connecticut Children's Center for Care Coordination:

- American Hospital Association case study: "Connecticut Children's Medical Center – Connecticut Children's Center for Care Coordination"
- Connecticut Children's Medical Center web page: "Care Coordination Collaborative Model"
- Connecticut Children's Medical Center document: "Protective Factors Framework"
- Connecticut Children's Medical Center document: "Raising healthy, successful children takes more than just health care"

Better Health through Housing Partnership:

- American Hospital Association case study: "University of Illinois Hospital & Health Sciences System's Better Health Through Housing Program"
- National Alliance to End Homelessness: "Housing First"
- Smart Policy Works case study: "Better Health Through Housing—the UIC Experiment"
- UI Health web page: "Better Health Through Housing"

Filmore County Hospital's Partnership with Local Public Schools:

- Bryan Health case study: "Hospital and school district partner for emotional health"
- *Healthier Nebraska* article: "State-Of-The-Art Mental Health Services at Fillmore County Hospital"