Where do we go from here?

The Hospital Leader's Role in Community Engagement

Building on a long-standing collaboration around improving hospitals' connections with their communities, the W.K. Kellogg Foundation (WKKF) approached the Health Research and Educational Trust (HRET) with a request: Help us understand how hospitals can take the next step in improving community health and engaging with their communities.

During the 1990s and early 2000s, WKKF and HRET collaborated on the Community Care Network Demonstration Project and its evaluation, a major national project that demonstrated that public-private partnerships could, in fact, make a difference in how health is produced at the local community level. Many of these partnerships continue as examples of some of the best hospital-community partnerships in the country. The demonstration and evaluation produced valuable lessons about how hospitals can work with their communities, lessons such as the need to have three-component leadership, consisting of a committed core, an organizational driver, and subsidiary leaders. Flexibility was another key characteristic of successful partnerships—the ability to reposition assets, competencies, and resources to address changing needs and priorities. These and other lessons from the Community Care Network project were disseminated to the field through publications, presentations, and electronic media, and are still available from HRET.

Yet today the community work of many hospitals and health systems remains at the level of a series of good programs and has not led to long-term change in the way health is produced or health care is delivered. Many hospitals still choose to work on their own, rather than in partnership with other community organizations and civic and citizen leaders.

To look at what might be next steps for hospitals, HRET proposed to bring together leaders from hospitals and health systems around the country that were exemplars of what both WKKF and HRET wanted to see—health care providers able to really connect with their communities, to affect both public and private policy, to improve the health of their constituents. The timing was right; America's hospitals today are making a concerted effort to reconnect with their communities, in ways large and small.

With generous support from Kellogg, HRET was able to convene some of the nation's best health care thinkers to address one question: How can hospitals engage their communities to improve the health of everyone? We all know this is not a simple enterprise. It is a long-term process, one that probably needs to be a little bit different in every community, but for which some common processes or ways of thinking might be helpful. This paper reports the result of our day-long conversation, as well as subsequent reflections by members of the panel, including those who were not able to attend the meeting. It represents some of the experience of leaders who are making a difference in their own communities, but is only a first step, laying out some options that have been tested and proven successful.

Each of the panel members was not just willing to work with us, but passionate about the need for some of the key ingredients in achieving change. We are indebted to them for their time, energy, and commitment. And we are eager to continue with them—and with you— on the path toward improving the health of our nation's communities.

Back to Our Roots, with a Change

In their very first days in the 19ᵗʰ century, hospitals were religious and charitable institutions designed to care for the sick, especially the poor. Towards the end of that era, hospitals went through a revolution. The resulting institutions provided medical care designed to cure disease, and the patient population broadened to include the middle and upper classes. Philanthropic contributions from community members were mainstays of hospital support. In the last decades of the twentieth century, as philanthropy was no longer able to keep up with rising medical costs, increasing emphasis was placed on making hospitals run more like businesses and less like charities. The adoption of managed care and other new health insurance mechanisms contributed to this changing emphasis.

Today we see the beginnings of a second revolutionary change to a greater focus on managing chronic disease (often with no "cure" in sight), providing primary care, and even preventing the development of disease. But we are also going "back to the future"— recognizing the need to re-emphasize the charitable mission of the hospital and reconnect with the communities our hospitals serve.

Thus the most basic reason for putting more energy and resources into community engagement is simple: Health is our mission. It's why people become health care administrators, doctors and nurses, hospital board members. And we need the community to be involved if its members are going to be healthy. As health care providers, we may think that medical care is the main ingredient in producing health, but in reality, medical care contributes only 10% to the production of health. Much more important are environment, individual behavior, and genetic make-up. Today we cannot do much if anything about the latter. But if we are to improve health, we must attend not only to medical care but also to the environment and to behavior, and that involves the community.

More specifically, 75% of U.S. health care spending goes to preventable diseases. It is clear that anyone who wants to improve the health of the population must look not only at how to treat diseases but also at how to create vibrant, caring, sustainable communities and support healthy lifestyles. This is true whether we look at cigarette smoking as a cause of cardiovascular disease, lung cancer, and other chronic conditions; at unhealthy diet and lack of available and affordable healthy food as a cause of diabetes; at suburban automobile use or urban violence as reasons why children don't get enough exercise; at stigma as a reason that people don't get tested for HIV; or any number of other social factors that cause any number of chronic conditions. There are many ways that hospitals can work toward the goal of having healthy communities; it is perhaps by focusing on the prevention and management of chronic disease that hospitals can make the greatest difference.

A society of healthy communities where all individuals reach their highest potential for health

Vision of the American Hospital Association

There are additional compelling reasons for health care leaders to be engaged with their communities. The first is that it can help the financial bottom line of the hospital. Any business is better off when it is located in a community of healthy people. Because health, education, and economic status are inextricably tied together, hospitals located in "healthy communities" find it easier to attract and retain a productive workforce. In a community with low unemployment, more of the patients will have health insurance, and they will be healthier to begin with, less likely to use expensive emergency room services or to develop clusters of chronic disease. More directly, community philanthropy (as a result of the hospital's active presence in the community) can be an important supplement to private and government reimbursement.

Looking to the future, we are seeing an increase in chronic disease as the population ages, the percentage of women increases, and the number of immigrants coming to this country—many with histories of no medical care within a formal system and with backgrounds of poor nutrition and limited resources—also increases. Preventing the development of chronic disease and promoting primary care and early diagnosis are ways that hospitals can begin to manage the demands on the health care provider system. If demand is not limited, pressure on the current system will grow, limiting the ability of hospitals to invest in information technology, quality improvement, replacement of aging facilities, and all the other needs of the system. Again, given that much of prevention resides not in medical care but in the home, the school, the workplace, it is critical that hospitals work with and within their communities.

Looking at the same issue from a slightly different angle, 10% of the population accounts for more than 60% of health care spending. Many of the most common procedures are not well reimbursed by the current system. Thus focusing on managing common chronic conditions and even preventing their development could improve the hospital's financial position by decreasing the number of poorly reimbursed services needed by this portion of the patient population.

Community support also can affect a hospital's financial position in less direct ways, by providing political support for legislation or regulation that affects reimbursement for current or new services. Today, as concern rises about the tax exempt status of not-for-profit hospitals, it is imperative that hospitals be able to demonstrate the extent of the benefit they provide back to their communities. Along with numbers, the health care leader who can bring other community leaders to the table to describe the key role of the hospital in the community has an advantage in any discussion of charity care and community benefit.

"We need to put programs in place not only to bring [community members] to the hospital but also to keep them out of the hospital."

Richard Parks

"Prevention is a key. It's the right thing to do and it's the best use of resources. … Many of the problems we see in the ED can be avoided."

Dan Coleman

FOCUS: CRITICAL COMMUNITY ISSUES

- Substandard housing
- Unemployment
- Domestic violence
- Child abuse and neglect
- Substance abuse

FOCUS: CRITICAL HEALTH ISSUES

- Chronic conditions
  (cardiovascular disease, diabetes, asthma, etc.)
- Obesity
- Immunization
- Oral hygiene; dental caries; related dental disease
- Mental health

FOCUS: EQUITY IN HEALTH CARE

- Health status disparities among racial
  and ethnic groups
- Lack of access to health care

FOCUS: SYSTEM BARRIERS

- Lack of care coordination for chronic diseases
  using integrated models
- Evidence base still in development and
  not easily accessible
- Lack of standardized definitions of community health
- Lack of metrics for community health
- Need for care process redesign
- Deteriorated public health infrastructure
- Lack of physician engagement
- No reimbursement/financial incentives for
  population health improvement
- Medical education that does not stress
  or assume community health

FOCUS: THE COMMUNITY'S ROLE

- Collaborate in care process redesign
- Accept personal responsibility for one's own health
- Reduce risk behaviors
- Examine environmental and economic supports
  for health
- Schools: Promote health careers

Sketch of a Community-Responsive Hospital

A merica's hospitals provide billions of dollars in charity care every year, but charity care alone is not enough. A hospital that is responsive to and engaged with its community provides benefit by addressing many different kinds of issues that the community faces. We can classify those issues into five different types (though there is overlap among them). Too often the hospital looks only at questions directly related to medical care, but there is a role for hospital leadership in all five areas. Here are a few examples of what hospital leaders can do to address issues in each of the five areas:

ACTION: COMMUNITY ISSUES

- Provide loans for housing
- Provide an educational program and counseling support for new parents at high risk for child abuse

ACTION: HEALTH ISSUES

- Support mobile dentistry facilities that travel to elementary schools to provide dental exams and sealants to the children
- Sponsor 5K walks to encourage exercise among not only their employees but also the rest of the community

ACTION: EQUITY IN HEALTH CARE

- Partner with a federally qualified health center to provide specialty care to their patients
- Develop a low-cost insurance plan for the uninsured

ACTION: SYSTEM BARRIERS

- Involve community leaders in care process redesign
- Collaborate with local public health leaders, business, and the nonprofit sector to develop a system for measuring community health improvement

ACTION: THE COMMUNITY'S ROLE

- Host health fairs at sites of employment and churches, mosques, and synagogues to provide *convenient* health education
- Partner with local schools to develop a health career path

"If [a system's] only access point is the ER, it has failed. It needs many access points."

Patricia Gabow

A critical factor in being a community-responsive hospital is thinking of the environment not just in terms of physical ecology, but also the built environment and the food environment. By partnering with other institutions in the community, hospitals can help create health and prevent disease in schools, in the workplace, in houses of worship, in the places that community members play. It is not just in clinical settings that hospitals can help improve the health of their community.

Moving Beyond Programs to Strategies

In a world of constrained resources, it is incumbent upon hospital leaders to make the most of those resources by following a well thought-out strategy for community engagement. Beginning with a realization that community engagement is more than just a series of isolated, "one-off" programs, even if they address issues of all five types identified above, it is more effective to be strategic and thoughtful rather than opportunistic in community engagement.

Needs Assessment: *Two Perspectives*

Two different approaches to community engagement are commonly used by hospitals and health care systems. The first starts by identifying and monitoring community health problems through needs assessment and performance management. It focuses on resolving problems and building community infrastructure with support from technical and scientific experts. The second approach is more community-centered in that it directly involves using members of the local community in making decisions about community health. It considers community values (including culture) and identifies community strengths on which to build improvements. The first is sometimes viewed as a "deficiency model"; the second, as an "asset model." Each of these approaches has merit, and they are often used together.

It is not uncommon for hospitals, alone or in partnership with other local organizations, to do an assessment of community health needs. Providers feel, with justification, that they are experts and have a sophisticated understanding of health data. Public health data may be used to determine the major causes of death or causes of death and disease which disproportionally affect a community. Hospitals (especially sole community providers) may look at their own internal data to see the most frequent diagnoses of their patients. This kind of information is important and can inform resource allocation decisions and decisions about strategic direction.

What this approach does not consider is what the members of the community feel are the most pressing health problems they face. The only way to determine that is to ask the community members themselves—through surveys, patient interviews, community meetings, or other direct contacts with them. Assessing the community's views of the community's needs has multiple benefits:

- It demonstrates the commitment of the hospital to community engagement.
- It increases community "ownership" of any program that the hospital creates in response.
- It may surface issues that are not shown in the data, especially if there are currently insufficient resources or programs addressing those issues.
- It identifies possible areas for collaboration.
- Most importantly, it increases the likelihood that the resulting initiatives will be effective because the community will be receptive and will participate.

Health care leaders in Franklin County, Maine, hold a Community Health Visioning process every two years to identify and prioritize community health needs. The first step is a survey that is conducted at the county fair, the Apple Pumpkin Festival, senior centers, and in many other community settings. Small meetings are held around the county, and culminate in a community conference at which findings from the survey and the meetings are discussed and community members and leaders jointly decide on a course of action.

Past conferences have led to the identification of need for and subsequent development of programs that have greatly improved transportation services, expanded mental health and dental health services, and increased health education. Most recently, the visioning process led to an audit of domestic violence and a report including action steps to address this problem.

Lesson learned: Holding the visioning process regularly—in this case, every 2 years—and following up with action tells the community that their health care leaders are truly listening to and hearing their concerns and that new priorities emerge based on the current state.

Choosing Strategies: *Using the Evidence Base*

Medical care rests on the basis of scientific evidence but until recently that evidence base was focused almost entirely on the provision of acute care. In the past several years, facing external pressure from the public and the payors, the health care provider community has also been working to improve quality of care and patient safety—particularly, again, in the acute care arena. Thus there is now a substantial and increasing evidence base for quality and safety improvement. Unfortunately, in the past we have not had a rigorous basis for community health improvement or prevention and management of chronic care. However, more recently that evidence base has been growing. The CDC is one source of information that can provide hospitals with the evidence needed to predict that the initiatives that they undertake will, in fact, be effective. Community health may have garnered a reputation of being "soft," but today at least some activities may be as strongly based in science as acute medical care is. Given what we know about the importance of behavior and environment in producing health, what we now need is a combination of both heart and head—community engagement, needs perceived by the community, and the evidence of what works.

A Necessary Component: *Ways to Measure Progress*

One of the serious obstacles to community health improvement is the lack of systems to measure and therefore monitor and report progress. While sole community providers may be able to get public health data, the more frequent case is that it is virtually impossible to define a catchment area for any single institution. Some hospitals cover multiple counties or parts of several counties; others cover only a small section of one county, city, or township. How do you show progress without data? The answer is, you can't. Even more basic, there are no standardized definitions or metrics for population health status. The ideal: Making data-driven, evidence-based resource allocation decisions to tackle the health priorities identified by the community. To do that requires (1) a system of performance indicators that are tied to the community's priorities and clinical evidence and (2) a willingness to look for and use *proven* tactics to address those priorities. Too often we do what is easy, convenient, or quick, rather than tackling the hard work of identifying what works and implementing those solutions.

St. Vincent Charity Hospital in Cleveland is located in a predominantly poor African-American neighborhood. The hospital had a history of being a tertiary care center but wanted to improve its relationship with and market share in its immediate neighborhood. The leaders looked at neighborhood data on illness and mortality, and it was immediately obvious that the numbers for heart disease and certain cancers were sky-high in comparison to other neighborhoods. Thus they planned to start a local campaign to prevent and treat cardiac care, a field in which St. Vincent was a city-wide leader.

Fortunately, however, they took a step back and decided to ask the residents first. They talked to both local community leaders and randomly selected residents. After compiling the results, the hospital's leaders enlisted leadership participation from the local city council members (one of whom went on to be elected Mayor), local public housing, and the community college (one of the area's largest employers). Together, those four organizations hosted a community meeting to prioritize the issues that had surfaced. The result—Two key needs were identified: (1) better access to primary care and (2) more safe activities available to the children in the neighborhood. The process gave the hospital leaders the information needed to develop programs that would be responsive to the community. Other key partners in this effort were community-based social service agencies and the developer of local affordable housing, who provided facilities and ongoing support. Once the priority needs were addressed, they could move on to cardiac care.

Lesson learned: Listen to the community; the residents may have concerns that are not top-of-mind to health care leaders.

Truckee Meadows Tomorrow (TMT) is a collaboration among business owners, community leaders, educators, and active citizens of the Truckee Meadows region (around Reno and Sparks) of Nevada. In 1996 Washoe Medical Center (now Renown Health) provided seed money to TMT because they believe "community health and quality of life go hand in hand." Some of that funding was used as program funding to a broad range of nonprofits, with the rest supporting operations over 8 years.
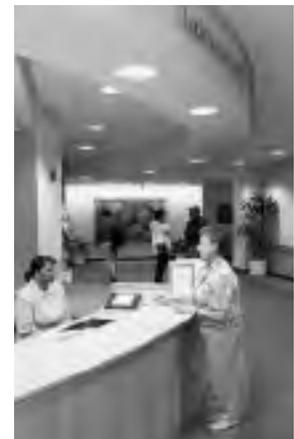
With input from nearly 4000 stakeholders, TMT organized the selection of a set of quality of life indicators; that indicator set has been updated over the years as priorities have shifted. The indicator set includes 10 categories such as "arts & cultural vitality," "economic wellbeing," "land use & infrastructure," as well as "health & wellness."

One of TMT's current programs is "Adopt an Indicator." In this program, an organization goes through four steps: (1) choose an indicator, (2) make and agree to a plan to move an indicator in the desired direction, (3) log progress with TMT, and (4) celebrate success. TMT is the central clearinghouse that recognizes participation at all levels and supports the partners. One area in which the indicator set has been used to effect change is housing; decreasing availability of affordable housing led to increased investment in affordable housing. Thus through a generous but time-limited act, Washoe Medical Center has been able to leverage its funds for much greater outcomes—in a much broader realm— than it would have been able to do on its own.

 "Standardization [of definitions and indicators] will lead to metrics. It creates healthy competition in the provider community. It inspires thinking, moving, and investment. It creates a common agenda between … provider organizations."

Stephen Ummel

But it is not enough to define measures and collect information. That information must be shared with the community. Whether through report cards, community meetings, web sites, newsletters, annual reports, or any other medium, hospitals and their partners must share their work and its results with the community regularly. Sharing real information demonstrates that the hospital is a part of and a partner of the community; it is an important step in building trust.

No Man Is an Island

Thinking again about the five types of community health issues, it is clear that these issues cannot be addressed by health care leaders alone. Cross-sectoral collaboration is a *sine qua non* if we are to make real progress in addressing complex community problems. By enlarging the set of partners, you bring resources of many sorts to the table: substantive expertise, knowledge of cultural sensitivities, financial help, and authority and credibility with community groups. Involving people helps them understand the complexity and difficulty of solving deeply rooted problems. It helps avoid redundant or un-productive efforts that waste precious time, energy, and money. It helps develop the community's sense of owner-ship of the effort, which in turn can lead to political support or advocacy not only for a specific initiative, but more broadly builds support for the hospital in other areas as well. While cross-sectoral collaboration is not easy, and not quick, it is well worth the effort. One often-overlooked resource is retired seniors—including physicians and nurses—who may have time to invest along with substantial expertise and experience to contribute.
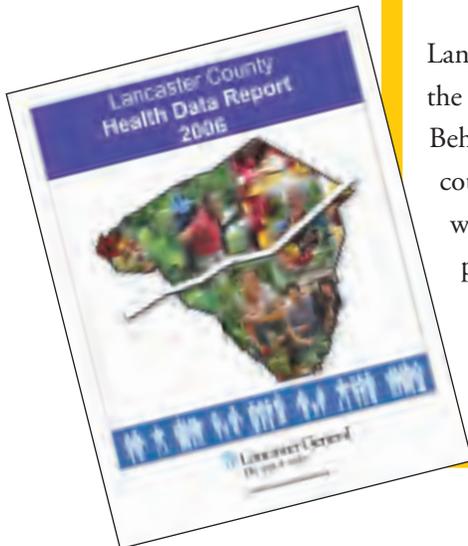
Lancaster General Hospital publishes an annual report of health statistics for the entire county. Using data from the state Department of Health as well as the Behavioral Risk Survey, they compare Lancaster County to 3 neighboring counties, the state of Pennsylvania, and the Healthy People 2010 goals. Along with a community health assessment, the data are then used to help set priorities for the delivery system, crossing service lines as well as facilities. The report is available on Lancaster General's web site, with easy-to-understand graphics such as arrows depicting whether the trend is up, flat, or down.

PARTNERS: CRITICAL COMMUNITY ISSUES

- Schools
- Business / employers
- Elected officials
- Health care organization trustees
- Faith community
- Local media

PARTNERS: CRITICAL HEALTH ISSUES

- Physicians
- Dentists
- Nurses
- Pharmacists
- Insurers

PARTNERS: EQUITY IN HEALTH CARE

- Faith community
- Community-based groups
- Activists
- Public health leaders

PARTNERS: SYSTEM BARRIERS

- Health care executives
- Physicians
- Public health leaders
- Insurers

PARTNERS: THE COMMUNITY'S ROLE

- Patients
- Schools
- Service clubs (e.g., Rotary, Kiwanis)
- Neighborhood block clubs
- Health care organization trustees

"We [hospitals] can't do it alone; we are a facilitator. When we think we're the solution, we have redefined the program in a different way and haven't solved it."

George Hernandez

Hospital as Catalyst

It is neither enough nor practical for the hospital to identify problems or initiatives and collaborate in their implementation with other community institutions and organizations. A better marker of success is when the partners make health improvement part of their own agendas. Do the schools change their vending machine policies to value children's health over easy income? Do employers pay for their employees to go through smoking cessation or exercise programs that are not reimbursed by insurance? Do churches monitor the menus at fundraising functions? It is a mark of success—or at least progress—when a variety of public and private institutions have incorporated wellness or disease prevention programs into their own agendas.

Mount Sinai Hospital is on Chicago's West Side, in a very poor, largely African-American and Hispanic neighborhood. Many problems are obvious—poverty, lack of good housing, crime, substance abuse. But Mount Sinai's leaders have looked beyond the obvious. CEO Alan Channing reports, "We've looked at the hearing impaired community, and we now have a model [deaf access] program, which has won awards. We found people to link to the community, including physicians and interpreters." Mount Sinai has also moved to focus on disease intervention at the neighborhood level, starting with diabetes and asthma. By influencing behavior change and providing health education, Mount Sinai has been able to see a decrease in emergency department visits and an improvement in school attendance by children with asthma.

A Critical Partner: The Physicians

Just as the role of hospitals is currently changing, so is the role of the physician in the hospital and the relationship between the hospital and its medical staff, influenced by changing compensation mechanisms and organizational models. No matter what the economic relationship between the hospital and its physicians, when physicians are engaged and committed, hospitals are better perceived and more successful in working with their communities.

Within every institution, there are likely to be individual physicians who are committed to community service and engagement. The hospital leaders should identify those physicians and train them to be champions with their colleagues, through heading up programs, serving on the hospital board, or simply acting as advocates. It may be easier to engage physicians by acknowledging the time and financial pressures they face, or providing compensation, if possible. Physician involvement is particularly important in addressing health issues, issues of equity, and delivery system barriers. Because of the respect connected with the physician role in society and in the health care system, they are a necessary (though not sufficient) ingredient in a strong community relationship.

Another Critical Partner: Business

Three main organized groups pay for health care in the United States today:
- Private providers themselves, through uncompensated care, bad debt, and low payment rates
- Business, through employer-based health care insurance
- Government, through Medicare, Medicaid, and federal, state and local provision of services

(Of course, patients themselves pay through their out-of-pocket expenses and higher prices for consumer goods that incorporate the cost of employment-based insurance.) Most traditional reimbursement systems do not pay for prevention, for health education, for community programs—the many different activities that health care systems might undertake to improve the population's health.

"We do need the business community at the table on all these community engagement issues."

John O'Brien

In its role as community member as well as its role as payer of health care costs, business can play a key part in any effective effort to improve health. Business leaders are a core group who should be called upon not only to provide insurance for their own employees under the current system, but also to advocate for and help design systemic change. It is in their own best interest to have healthy employees and to market their goods and services to healthy consumers. And business has a serious incentive to reduce health care costs.

Business leaders can help identify the critical community issues, can assure that their employees' health issues are covered by the insurance they provide, can assure that their employees receive equitable health care coverage, can use their own experience to help devise solutions to delivery system barriers at the local level, and can support prevention and wellness efforts that are not covered by insurance.

"Hospitals have been unfaithful in improving the health status of our community, though it's in everyone's mission statement. … We need to look at the budget and strategic plan. Is there any indication in either one of those tools that we are going to get there or that we are on the right course? We need to look at the annual compensation plan—does it have a goal with an incentive attached?

Stephen Ummel

Changing the System

In the end, to improve the health of the people of this country, we must have policy change at every level. Individual health care organizations can provide incentives for their administrators and physicians to address community health. Insurers can incorporate pay-for-quality into their reimbursement schedules. Hospitals and other community institutions can advocate for changes in the built and food environments. But government is the core influence on the shape of the health care delivery system.

Both the reimbursement system and the regulatory environment affect how health care is delivered. Some decisions and some change can come from the community level and at the state level, but their reach is limited by definition and by the federal government's regulatory and financing influence. To change the system, we need active citizen participation and informed and educated policy makers. And it is up to the health care community to mobilize their neighbors and educate their representatives at all levels of government. Health and hospital advocacy associations, at the national, state, and metro levels, have all begun to undertake this challenge, but much remains to be done. The voice of individual leaders—those with "boots on the ground"—can be a powerful force reinforcing the work of their associations.

What Do We Do Next?

At the same time that we work toward major system change, there are many things that can be done today at the local level. A single health care organization, with dynamic, committed leadership, can make a big difference: in the lives of its patients, in the lives of its employees, and in the health of its community.

We can also help each other by sharing information about what works, what is showing promise, what "sounds good" but is unproven. While the focus of change is the community and programs need to be tailored to fit each neighborhood, town, city, or state, there are many lessons that we can and should share.

Chicago's Mount Sinai Hospital has looked at both local and national data on health care disparities and is using that data to call for change at the local level. One of their targets for improvement is smoking rates, based on data showing that smoking rates among minority group members in Chicago are the same as the rates for the US as a whole 35 years ago. A second target is breast cancer detection. Data from 2004 show that African-American women have breast cancer rates greater than US Caucasian women by 20,000 per 100,000 women. Mount Sinai leaders have called for a city-wide task force to increase mammography among minority women, noting that there are agreed-upon—but not required—standards for mammography use.

"Very few people from health backgrounds are making law, or involved in politics. If we're really interested in transformation and reform, let's mount a concerted effort over time to get more health professionals in elective office."

Stephen Ummel

"[But in talking about] putting more health professionals in legislative seats—it's not about people but the *right* people."

Patricia Gabow

> **"We have to overcome the sense that many hospitals have that their situation is so much more difficult than other hospitals, that they can't afford to do anything more than they're doing."**
>
> **Dan Coleman**

> **"If we believe that government has a role, a key component in community mobilization is getting people politically active or engaged and voting."**
>
> **Patricia Gabow**

NEXT STEPS: CRITICAL COMMUNITY ISSUES

Get out of the office and into the neighborhood to find out what people care about. *"If you're talking about engagement, you have to walk the talk: need to have those [community] relationships, develop those relationships, and be part of the solution."* Michael Mahoney

NEXT STEPS: CRITICAL HEALTH ISSUES

Develop programs designed to keep people out of the hospital, such as culturally targeted cooking, nutrition, and physical fitness classes for families with members who have diabetes.

NEXT STEPS: EQUITY IN HEALTH CARE

Hire staff who live in and are representative of the racial and ethnic communities the hospital serves, as well as staff who speak the primary languages spoken by the patients.

Work with local immigrant groups to encourage their constituents to think about health care as a career.

NEXT STEPS: SYSTEM BARRIERS

Create a web site that reports patient charges and patient care outcomes to increase transparency and increase public trust.

Host a forum for community dialogue based on local health data, to lead to an increase in the public will for change.

NEXT STEPS: THE COMMUNITY'S ROLE

Partner with local schools to design and implement a health careers curriculum. *"Medical school and college are too late. We need to go into junior high schools and high schools to help develop workforce awareness and knowledge."* Paul Nannis

Work with the schools to change their food, vending machines, and physical education policies.

Next Steps: The Big Picture

There is much known about community health improvement, and more yet to learn. A first step is to develop tools to help health care organizations in their work to engage their communities. At a minimum, we need:

- A clearinghouse of leading, evidence-based practices for community health improvement
- Accepted standards of practice for community health improvement
- Standardized definitions and metrics for community benefit

But individual organizations and communities can only do so much. At the national level we need political action and political will. There are many possible things we can do to mobilize change:

- Start by acknowledging that the system is broken, and that change must address the system as a system, not as individual pieces and parts.
- Identify a neutral person, someone well respected from outside of health care, to engage people. Hold regional forums.
- Hold forums with the largest (Fortune 500) companies. Encourage media coverage.
- Engage the national mayor's group, which tends to take pragmatic positions. Mayors are in touch with the problems of their own communities.
- Create a plan and publicize it. Inform political debate.

If the United States is to be competitive and secure in the 21st century, we need healthy children, healthy workers—healthy communities. We need a different health system *and* a different health care system.

"The big idea: let's work to create what a rational health system would be and how we get there in our lifetime."

Patricia Gabow

APPENDICES

Panel Members

***John G. O'Brien**, President and CEO, UMass Memorial Health Care, Inc., Worcester; **chair**

Richard A. Batt, President and CEO, Franklin Memorial Hospital, Farmington, ME

John Benz, Chief Strategic Officer, Memorial Healthcare System, Hollywood, FL

John Bluford, President and CEO, Truman Medical Center, Kansas City, MO

Sandra Bruce, President and CEO, St. Alphonsus Regional Medical Center, Boise, ID

***Alan Channing**, CEO, Mount Sinai Hospital Medical Center, Chicago, IL

Dan C. Coleman, President, John C. Lincoln Health Network, Phoenix, AZ

Matthew Fishman, Director, Community Benefit Programs, Partners HealthCare System Inc., Boston, MA

Spencer Foreman, MD, President, Montefiore Medical Center, Bronx, NY

***Patricia A. Gabow**, MD, CEO and Medical Director, Denver Health Medical Center, Denver, CO

***George Hernandez**, President and CEO, University Health System, San Antonio, TX

Dennis D. Keefe, Chief Executive Officer, Cambridge Health Alliance, Cambridge, MA

***Michael P. Mahoney**, President and CEO, St. Rose Hospital, Hayward, CA

***Paul Nannis**, Vice President, Government, Community & Public Relations, Aurora Health Care, Milwaukee, WI

***Tyler Norris**, Boulder, CO

John M. Palmer, Executive Director, Harlem Hospital Center, New York City, NY

***Richard Parks**, CEO, Cape Fear Valley Health Systems, Fayetteville, NC

Phillip D. Robinson, CEO, Bayshore Medical Center, Pasadena, TX

***Stephen L. Ummel**, Director, Healthcare Advisory Practice, Pricewaterhouse Coopers, LLP, Chicago, IL

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Deborah Bohr, Senior Director, Special Projects

Romana Hasnain-Wynia, Vice President, Research

Cynthia Greising, Staff Writer

* **Frances S. Margolin**, Vice President, Operations

* present at meeting

HRET Resources on Hospital-Community Engagement

Publications

*Community Care Notebook:
   A Practical Guide to Health Partnerships*

*Report of the National Steering Committee
   on Hospitals and the Public's Health*

*Beyond the Medical Model:
   Hospitals Improve Health Through
   Community Building*

*The Collaboration Primer:
   Proven Strategies, Considerations
   and Tools to Get You Started*

*Hospital Response to Public Health
   Emergencies: Collaborative Strategies*

*Public-Private Partnerships
   to Improve Health Care*

*Sustaining Community Health:
   The Experience of
   Health Care System Leaders*

Web sites

American Hospital Association
www.caringforcommunities.org

Association for Community
Health Improvement
www.communityhlth.org

Health Research and Educational Trust
www.hret.org

See also W.K. Kellogg Foundation
www.wkkf.org

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Founded in 1944, the Health Research and Educational Trust (HRET) is a private, not-for-profit organization involved in research, education, and demonstration programs addressing health management and policy issues. An affiliate of the American Hospital Association, HRET collaborates with health care, government, academic, business, and community organizations across the United States to conduct research and disseminate findings that shape the future of health care. For more information about HRET, visit www.hret.org.