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Wendy Jameson, MPH, MPP, is Director of the California Safety Net Institute, which is a research and educational affiliate of the California Association of Public Hospitals and Health Systems, dedicated to advancing community health through the resources and expertise of California’s public hospitals and health care systems, also known as “open door providers.”

Many of the major gains in health that Americans have enjoyed over the past century, such as reduced infant, child and maternal mortality and increased life span, were driven by public health interventions. Clean drinking water, food safety, pest control and other sanitation measures are just a few of the important practices adopted as a result of public health advocacy and education.

Faced with the persistent, complex issues that plague our communities, such as violence, substance abuse and the many negative health effects of poverty, no one entity can fix it alone. Improving community health requires involving the entire community: residents, community-based organizations (CBOs), public health and related agencies, and health care providers. Public hospitals and health systems play a special role in this ensemble.

This Policy & Practice Brief details the roles and responsibilities of public hospitals and health systems and describes some of the effective collaborations in place in communities throughout California. It addresses both their challenges and successes, and offers advice on fostering successful partnerships.

The open door to health care for many

Public hospitals and health systems are known as “open-door providers” because their purpose is to serve all patients, regardless of insurance status, immigration status or financial ability, as mandated by Welfare and Institutions Code Section 17000. Located in 20 counties, public hospitals and health systems reach 80 percent of California’s population. Twenty-two public hospitals are owned and operated by the counties in which they are located; the remaining four (University Medical Center in Fresno and the University of California Medical Centers in Davis, Irvine and San Diego) provide services under contract. Public hospitals and health systems serve a patient population that is primarily low income and publicly insured, or uninsured—76 percent of whom are Hispanic, African American or Asian.

In addition to providing inpatient care, public hospitals and health systems provide 11 million outpatient visits per year, for both primary and specialty care. In many communities, they are the only source of specialty care for low-income, at-risk populations.

Even though they represent only six percent of California hospitals, public hospitals and health systems are responsible for nearly...
half of the outpatient visits made by Medi-Cal and uninsured patients, and provide 87% of the hospital outpatient care to individuals in the County Indigent Program. In counties where the public hospital system operates clinics for the county health department, the fact that both entities serve the same population of primarily low-income and uninsured or publicly insured individuals is underscored.

Most public hospitals are part of a larger county health care system, linked closely to the local public health department. Public hospitals often provide an array of services for the benefit of the entire community, including 24-hour Poison Control Centers, trauma care and burn units, for example. Most are teaching and research facilities, training almost half of the medical residents in the state, not to mention nurses, pharmacists and other patient care professionals.

A safety net of care

While both are key components of the health care safety net, public hospital systems and non-profit community clinics differ in many ways. Public hospital systems provide hospital and specialty care, in addition to primary care. Community clinics, on the other hand, generally provide only primary or preventive care.

As non-profit entities, community clinics are governed by boards of directors. Typically, public hospitals and health systems are governed by the county board of supervisors, but not always. The Alameda County Medical Center, for example, operates under the oversight of a local Health Authority. Other exceptions include the UC Medical Centers, which are governed by The Regents of the University of California, and the non-profit University Medical Center, which contracts with Fresno County, but is governed by an independent board of directors.

In many counties, the public hospital system and community clinics have developed strong referral and/or contract relationships to serve their similar and sometimes overlapping patient populations. These partnerships are often based on the critical role that public hospitals and health systems play in providing specialty care and hospital-based services to community clinic patients and other low-income residents.

Tips for Effective Collaborative Relationships

Launching a partnership

✦ Package your idea so it shows what the public hospital system has to gain (good public relations, funding, improved access or quality of services, resource savings).

✦ Do your homework; anticipate and be prepared to address potential areas of concern.

✦ Make the public information officer or director of public relations, community relations, or communications your first contact if you don’t know anyone in the hospital.

✦ Secure positive community support as appropriate.

✦ Demonstrate your organization’s track record for successful initiatives and show evidence of your good reputation.

✦ Demonstrate good will and offer something meaningful; don’t go to the hospital simply with your hand out.

✦ Be persistent in presenting your ideas.

✦ Empower public hospital system staff so they feel included in the process.

Sustaining the partnership over time

✦ Appoint and support a strong coordinator.

✦ Engage hospital administrators to maintain their enthusiasm and commitment.

✦ Connect with key leaders in the hospital system.

✦ Communicate regularly, especially when things aren’t going well.
A patchwork of funding

California’s public hospitals and health systems rely on a tenuous and unpredictable patchwork of funding based primarily on Medi-Cal revenues and state and local subsidies. Because these funding programs have not kept pace with the rising costs of, and demand for, health care services, the public health care safety net is vulnerable financially. When record-setting numbers of people lack health insurance and will need public hospitals and health systems more than ever, these open-door providers face a $3 billion deficit over the next three years, according to a report by the California Association of Public Hospitals and Health Systems. The current state budget crisis will only exacerbate funding shortfalls.

For example, Kern Medical Center, which is the only trauma center located between Fresno and Los Angeles, faces a $15 million operating loss this year, on top of $30 million lost over the last two fiscal years. Reducing staff and closing and restricting the hours of clinics saved money last year, but at a cost of limiting the hospital’s outpatient volume by 15 percent. In the San Francisco Bay Area, 80% of the patients who visit the Alameda County Medical Center are low-income or uninsured. The Center provides $31 million in uncompensated care annually, while operating at a $24 million budget deficit. Short-term service cuts to stabilize its finances may require closing its skilled nursing facility and eliminating or restricting some services.

Local health departments also face less-than-dependable funding streams, often tied to specific programs that come and go, making it difficult to provide continuous support to broad-based interventions. And, policymakers tend to reduce funding for long-term, preventive, community-based public health (CBPH) initiatives before cutting more immediate needs for treatment services, leaving local public health departments with few resources to support CBPH initiatives. These issues make it even more important for affected agencies and communities to seek opportunities to collaborate and partner, to make limited resources stretch the farthest.

The open door swings both ways

A shared commitment to improving public health, local community ties and involvement with many of the same populations would seem to make open-door providers ideal partners in CBPH. After all, public hospitals and health systems can offer CBOs resources such as:

- information, data and knowledge of patient and community needs;
- goodwill and the desire to help the community;
- health care, case management and patient support services;
- space;
- access to patients and their families;
- patient and services referrals.
- committed, knowledgeable staff, with linguistic and cultural competence.

In return, public hospitals and health systems stand to benefit from partnerships with CBOs by gaining:

- opportunities to prevent trauma and disease;
- improved health outcomes;
- community, political and financial support;
- opportunities to improve efficiency and effectiveness;
- positive public relations;
- enhanced relationships with key community leaders;
- opportunities for staff engagement and satisfaction;
- referral relationships with community-based organizations.

The challenges and rewards of partnership

These potential benefits, however, are accompanied by an array of challenges. Public hospitals and health systems often are complex organizations, overlaid with the bureaucracy that results from government oversight responsibilities. Precarious funding adds a dimension of uncertainty when it comes to establishing and nurturing long-term relationships.

Yet, the experiences of open-door providers, local health departments and CBOs up and down California demonstrate that these partnerships can work. The following examples highlight how CBOs, public hospitals and health systems have overcome challenges with strategic thinking, patience and ingenuity.

Challenge: Maneuvering through complex policies and procedures

A partnership between the Contra Costa Health Services Department and the Center for Health Advisory Board, representing residents and key organizations in North Richmond and surrounding neighborhoods, started out “on a bumpy road, but is hitting smooth pavement now,” according to Center Manager Chinyere Madawaki, MPH.

North Richmond in West Contra Costa County is one of the poorest communities in the state, characterized by poverty, persistent unemployment, violence, toxic exposures, HIV/AIDS, TB, low birth weight, substance abuse and chronic disease. The
Center for Health was founded with money obtained in a settlement with a local chemical plant and other funds, including a local refinery, a Community Development Block Grant and county funds, following a toxic release. Community leaders formed an Advisory Board to ensure community participation in all decisions related to the Center’s design, development and array of services.

In addition to initial mistrust of the system, the Advisory Board didn’t always understand some of the restrictions and policies that Health Services had to work within. “We are a large health care system, taking care of 110,000 people across Contra Costa County,” says Mary Foran, Assistant Director, Contra Costa Health Services. “Things like a centralized appointment system and screening and payment policies are part of the way we have to do business. Plus, we have to make sure we can get reimbursed for the services we provide. Money will always be limited and we have to allocate it wisely. It is sometimes hard to reach agreement with community members, but we keep on talking.”

Persistence is paying off, especially in educating the community about what the Center can and cannot do. “I call it ‘Ambulatory Care 101,’” says Madawaki, describing her presentations to community members. “I explain what ambulatory care is, how it’s different from emergency care. Once people understand the distinctions and the negative impact that something as simple as a missed appointment has on cost and productivity, they can discuss options much more responsibly. We are moving past frustration to cooperation.”

On the eve of its fourth anniversary, the Center for Health provides primary medical care, HIV and AIDS care and case management, and health education by Public Health Nurses. With support from PPH and other sources, the community and the health department are focusing more attention on asthma, TB, environmental and youth issues.

**Challenge: Coping with expectations**

From the start, San Joaquin General Hospital and Su Salud had a lot in common. They both serve the same population of under-served, uninsured and working poor, 70% of whom are Latino. San Joaquin General Hospital logs 227,000 outpatient visits each year, and Su Salud had a successful track record of drawing as many as 20,000 people to its annual community health fairs.

In 1999, Su Salud needed to cut costs and relocate from the building it had leased in downtown Stockton. “The hospital had resources—space and referral sources—and Su Salud had energy and a name,” recalls Su Salud board member Al Murillo, who also serves on the Partnership Coordinating Committee for a PPH-funded partnership with San Joaquin County. With the cooperation of the county health director and county hospital administrator, and after a series of presentations by Su Salud staff to hospital medical staff explaining the purpose, Su Salud was invited to open a year-round Community Disease Prevention and Education Center in the hospital’s main lobby. The Center offered a multilingual video education center, health education exhibits, health education classes in Spanish and English, health and dental screenings, and eligibility determination services for public health insurance programs.

“We expected people would visit the Center while waiting for their appointments or for their prescriptions to be filled, which can take up to two hours. We saw it as easy, one-stop shopping,” says Lita Wällach, Director of Strategic Planning and Development, San Joaquin Health Services Agency. Experience didn’t fully lived up to that expectation. While many people took advantage of the Center, an even larger number did not. The reasons are unclear, but most likely include: fear of not hearing their name called for an appointment; the distraction of having children with them; and the reluctance to spend any more time than needed at the hospital.

In addition to lower utilization than expected, the failing health of its key champion and dwindling financial support led Su Salud to close in April. Of the closing, San Joaquin General
Hospital Director Steve Ebert, says, “We certainly want to continue Su Salud’s legacy as far as patient education and prevention. The hospital medical staff and others will meet soon to determine what we can utilize from this partnership to provide opportunities through our outpatient services to focus on health education.”

Challenge: Negotiating cultural differences
Health care delivery and academia each have a distinct culture, and bridging the two is critical when it comes to encouraging and teaching the next generation of health care providers. Several partnerships among the Central Valley’s medical and educational establishments show how it can be done.

Since 1985, East Bakersfield High School’s Health Careers Academy (HCA) has sent juniors and seniors to observe and assist in virtually every department of the Kern Medical Center (KMC). “Our students do everything from take vital signs in clinics to streak slides in the microbiology lab and translate for patients in the ER,” says HCA Director Dianna Anderson. The students learn valuable workplace skills and become aware of the broad range of jobs needed to keep a hospital running. They also get a new perspective on KMC and often become advocates for the hospital, helping their families and friends navigate the system.

Given that most teenagers are convinced of their own invulnerability, being at the hospital exposes them to a range of human suffering they might not otherwise see. “They are sensitized to the consequences of behavior and lifestyle choices related to drinking and drugs, unsafe driving and others that they will face in their own lives,” says Peter Bryan, KMC’s CEO.

Far from resisting the time commitment required to mentor the HCA students, “our staff remembers when they were students and are willing to invest in these kids because they are the future,” says Renita Nunn, Hospital Employment Specialist at KMC. “We are a teaching hospital and a learning organization.”

In Fresno County, academia and hospitals bridge cultural differences to address a dire nursing shortage. Community Medical Center is part of an Academic Partnership that includes administrators, staff and faculty from all of Fresno County’s hospitals, Fresno City College and Fresno State University. “We started by asking the educators to think of the hospitals as their customers—unhappy customers,” says Pilar De La Cruz-Reyes, Executive Director of Education and Community University, Community Medical Center. “We quickly went from pointing fingers to solving problems.” The result is greater hospital participation in curriculum decisions and better, more standardized training and orientation among all of the hospitals.

In addition, the Paradigm Program, started in 1999, guarantees a certain number of Community Medical Center staff members who have completed the prerequisites for nursing school, or who are LVNs seeking to get their RN degrees, placement in Fresno City College nursing classes. “We’re growing our own nurses, most of whom stay in the community after graduation,” says De La Cruz-Reyes. “This not only fills our need for nurses, it adds employment opportunities for local residents.” Today, Fresno City College has the largest nursing education program in the state.

Challenge: Limited funding and staff time
“It was frustrating to treat so many young victims of violence and release them with little or no follow-up care, only to see them back in the ER with even more serious injuries,” recalls Cesar Ursic, MD, Chief of Trauma at Highland Hospital, part of the Alameda County Medical Center. Ten years ago, that frustration was the impetus for a partnership between the Medical Center and Youth ALIVE!, an Oakland-based non-profit agency working with youth to reduce violence. The result is “Caught in the Crossfire,” a nationally recognized program that uses young “intervention specialists” to assist patients under age 20, hospitalized as a result of violent injury. They offer immediate crisis intervention services, followed by help with school, employment, credit and criminal justice issues, along with counseling. “Everything is geared toward keeping the youth out of the hospital and safe from retaliation,” says Nic Bekaert, MSW, Highland Hospital’s Community Injury Prevention Coordinator.

Partnerships like this are among the Medical Center’s corporate objectives, says CEO Ken Cohen. “Given the economic climate, we look for every opportunity to leverage our funding and resources. Groups like Youth ALIVE! help us offer services we wouldn’t be able to on our own. Medical professionals are used to working in teams, and this is a fine example of extending our team beyond the boundaries of the Medical Center.”
Bekaert uses one of the hospital databases to identify each of the 100-plus patients every year who meet the program criteria. Of those who qualify, 95% agree to participate. “We can have an intervention specialist at a patient’s bedside within 20 minutes of the consent form being signed,” Bekaert says. The results are impressive: youth served by the program are 70% less likely to be arrested and 60% less likely to have any criminal involvement than those who choose not to participate. During a single year, 98% of program participants avoided violent re-injury.

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Recognized by former U.S. Attorney General Janet Reno and President Bill Clinton, “Caught in the Crossfire” isn’t resting on its laurels. Bekaert would like to see the age ceiling raised to 25, to encompass the 18- to 24-age group, one of the most vulnerable to violent injury.

An open door to partnership
What best characterizes successful partnerships among communities, health departments and public hospitals and health systems is the recognition, by all sides, of the complimentary missions and purposes they share and the acceptance of each other as equals, with each partner bringing something to the table.

Public hospitals and health systems are natural partners in community-based health promotion initiatives. While such partnerships can be challenging, many of the strategies used by the collaborations described here can be applied to other efforts to create and sustain effective partnerships and improve community health.

FOR MORE INFORMATION

California Association of Public Hospitals and Health Systems – list of California public hospitals and health systems; policy and advocacy briefs on safety net issues; educational forums. http://www.caph.org

California Health Care Safety Net Institute – educational forums; publications on community health issues and the role of public hospitals and health systems; descriptions of programs on community health priorities; links to community health websites. http://www.safetynetinstitute.org

Community Toolbox – University of Kansas Web site available for community organizers to share their work. Offers how-to materials, guides for community problem solving and a general store with book and product recommendations. There is a section devoted to PPH grantees. http://ctb.ku.edu/services/pph


Web sites for public hospitals and health systems featured in this Brief:
Alameda County Medical Center: http://www.acmedctr.org/
Contra Costa Health Services: http://www.cchealth.org/
University Medical Center, Fresno: http://www.communitymedical.org
Kern Medical Center: http://www.kernmedicalcenter.com
San Joaquin General Hospital: http://www.sjgeneralhospital.com/

About this Series
The policy brief series is part of PPH’s commitment to its grantee partners; The California Endowment (that supports PPH); and the larger public health world. Each brief will define terms, identify challenges, share success stories and best practices, indicate issues for policy and systems change, and point towards key sources of further information. We encourage feedback and suggestions from our readers (please e-mail Adele Amodeo at aamodeo@partnershipPH.org).

Credits:
Special thanks to Denise F. Martin, President and CEO, California Association of Public Hospitals and Health Systems.
Photos courtesy of the Health Careers Academy, San Joaquin General Hospital and Su Salud.
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