Introduction: Where we started

Ten years ago, Durham County was in the midst of recovery from an economic crash caused by the declines in the tobacco and textile industries in the 1970s and 80s. It was a city formerly divided by race learning to live together. Key health problems identified in 2002-2005 included violent crime, sexually transmitted infections, infant mortality, obesity, an underinsured population, substance abuse, and a high chronic disease burden. Ten years ago, Durham was a community of multiple organizations addressing health issues without the benefit of collaborative planning.

Durham created a collaborative health partnership

During this period, the Department of Public Health (DCoDPH) took over the Partnership for a Healthy Durham (Partnership), an organization originally created to convene community members to improve health outcomes. The Public Health Assistant Director, Gayle Harris, apportioned funding for a coordinator for the Partnership and called a meeting of health-focused groups in Durham. A decision was made to join the groups together under the rubric of the Partnership. "We were acknowledging that we were really together, and were willing to have the Health Department sign on as lead in coordination" said Susan Yaggy, former Partnership committee chair.

In June of 2004, Durham County Commissioners and the Durham City Council launched a community-wide Results-Based Accountability project that was designed to strategically improve the quality of life in the community; this project included a health workgroup led by Gayle Harris, with MaryAnn Black, a County Commissioner. This opportunity linked the Partnership to funding. Applicants for county health funds needed to be connected to a Results-Based Accountability group, and being engaged in the Partnership was a way to do this. As a result, there was a significant incentive for participation in the Partnership, and the organization expanded to include more lead administrators from non-governmental organizations, as well as community members and health department staff. This link also helped county leaders and Partnership members create shared goals. The Partnership for a Healthy Durham is rooted in these particular opportunities, the linkage between a government accountability initiative and newly constituted, community-oriented coalition.

As key members of local organizations were regularly participating in Partnership meetings, it became a place to build relationships between leaders, partners, and community members. There are many non-profit organizations in Durham County. The Partnership, which is not a non-profit organization and does not compete for funds, occupies a neutral position in this landscape. In addition, organizations without an explicit health focus participate in the Partnership, enriching perspectives and opportunities for collaboration. "By bringing in non-traditional partners, the meetings became a shopping mall for creative approaches" said Susan Yaggy. Thus, the Partnership was established as a place to meet people, develop relationships, and create effective projects, and it was able to powerfully support collaborative work to improve health in Durham.

The Partnership structure supports the development of effective programs

The structure of the Partnership for a Healthy Durham supports health planning and decision making across the multiple factors that influence health. First, the Partnership offers a sustained space for collaboration. The Partnership has four committees that meet monthly, supported by a coordinator

who provides continuity and accountability as well as some administrative support. Although health priorities have changed over time, some Partnership committees have been meeting for 10 years. This provides a reliable convening space for planning and project development.

Second, the Partnership collects and distributes county health data and participates in strategic planning. The Partnership coordinator leads the triennial community health assessment. A report based on assessment findings supports a county-wide process for determining health priorities for the next three years. The Partnership committees are focused on these health priorities, and as such, they span the most important health factors in the county. Currently, these committees focus on: Access to Care, HIV and other Sexually Transmitted Infections, Obesity and Chronic Illness, and Substance Abuse and Mental Health. Because of the focus of the Health Director and Partnership members on the social determinants of health during the 2011 health assessment, Poverty and Education are also formal Partnership health priorities. As a result of this focus, collaboration with Durham Public Schools has grown, with current participation of Durham Public Schools staff in several committees; the Partnership collaborates with End Poverty Durham, and the 2012 and 2013 Durham Health Summits focused on the social determinants of health and resulted in successes and ongoing priority-setting in several areas. These priorities are shared goals; "We use the priorities to help plan how we'll use our resources in the next few years", said Mel Downey-Piper, Health Education Director, DCoDPH.

Third, the Partnership committees link stakeholders, and the coordinator has the ongoing responsibility to support connections among agencies and groups. For example, regular attendees of the Obesity and Chronic Illness committee include health care providers, DCoDPH staff managing community transformation and other grants, and community organizations. Collaborations among these groups have resulted in joint projects: for example, an after-school nutrition education program is planning to expand on the Partnership's Healthy Grocery Store Aisle efforts by asking students to plan for Healthy Aisle projects in their neighborhoods. Linked projects make the most of the scarce resources available for health promotion efforts.

Finally, effective linkages such as these are valuable to the participants. Because of this draw, the Partnership reflects the way the community is hitched together. This affects our projects, including recent projects focusing on the built environment. In response to community health assessment data showing that people wanted to exercise in their neighborhoods, several communities have participated in stenciling Healthy Mile trails on neighborhood sidewalks. The Healthy Checkout Aisle project was effective in recruiting stores to participate because members of the store's communities regularly attended the Obesity and Chronic Illness Committee and could inform the project about community expectations and norms. The Durham Open Streets/Play Streets project draws crowds because the events have been created and managed in collaboration with community members. These projects are effective because they are grounded in community knowledge and experience.

The Partnership's stability over time and the relationships created within the Partnership reflect how the community is linked. The Partnership structure supports the community in working across the multiple factors that affect health and in making the most of available resources.

Collaborative evaluation supports planning over time

In addition to serving as a point of connection and project-building, the Partnership structure supports review of health data and project evaluation. The Partnership story starts with the Results-

Based Accountability project – therefore, the Partnership roots are defined by measurement. Evaluation experts are part of partnership committees and are available for discussion and project planning.

Our measuring and reporting efforts begin with the community health assessment. Partnership members share health department and other data with the community. Modes of data access are discussed with community members as the community health assessment is conducted. In addition, the coordinator and committee members are available for presentations to organizations and community members. This link between the community health assessment and the Partnership and its projects makes for rich opportunities for evaluation. For example, questions about walking and biking in Durham, submitted by the Durham Bicycle and Pedestrian Advisory Committee, will be included in the next community health assessment survey.

All health priorities (and therefore all Partnership committees) have quantifiable evaluation measures. As required by North Carolina health department accreditation, all Partnership subcommittees have measurable activities and outcomes. For example, measures for the HIV/STI committee are the rates of HIV, syphilis, gonorrhea, and chlamydia; measures for the Access to Care committee include whether a forum for community discussion of respite care for the homeless was held and the number of adult dental screening clinics held between 2012 and 2015. These measures are used to evaluate committee efforts.

Our measuring and reporting is enriched by discussion. The Partnership structure supports discussion of measures in mixed groups with differing expertise. In other settings, discussion of evaluation is conducted among experts attached to a project, and can be very internally focused. Evaluation measures for Partnership projects are discussed in the committee meetings, attended by people with and without evaluation expertise. The result is vibrant, energetic communication around progress (or the lack of it). In this setting, evaluation planners have to stretch to explain their methods so that the committee can understand, and committee questions can be powerful. Recently, researchers from a local university and non-governmental organization presented results to the HIV/STI committee. The following discussion encompassed both the specific results of the project and other projects in the community, and led to further discussion with researchers about what kind of evidence-based projects would be productive in Durham. The Substance Abuse and Mental Health committee recently discussed evaluation measures for youth training on suicide prevention and gun safety; while validated evaluation measures for suicide prevention were easy to find, measures for gun safety were not, and the discussion identified the potential for developing and validating such measures.

Finally, the Partnership makes every effort to support communication about projects in the community. The Partnership coordinator presents health data (both local and external, such as the County Health Rankings) to the Board of Health and other county leaders. The Partnership works regularly with the paper to communicate via press-releases, editorials, perspectives, and articles. Media headlines linked to the Partnership include (among many others) "Expanded exercise-oriented even promotes pedestrians and pedalers" (Bull City Rising blog, 2011); "Fueling DPS students with healthy food" (Durham Herald-Sun, 2011); "AIDS deaths falling, but complacency is a problem" (Durham Herald-Sun, 2012). Currently, the Partnership Access to Care committee is planning a series of articles on the implementation of the Affordable Care Act and what that means specifically for Durham residents. The Partnership maintains a website (healthydurham.org) as well as a Facebook page and an extensive mailing list, all of which are used regularly. This commitment to communication helps support community discussion of health issues.

Leadership turns obstacles into opportunities

The Partnership offered a space for collaboration. But collaboration is difficult. As in all communities, there are tensions in Durham. As the largest employer in Durham County, Duke is a major stakeholder. It has enormous wealth and public stature; it also plays a pivotal role in access to care, in that it currently owns both hospitals and most of the clinical practices in the county. The acquisition of the single county-owned hospital by Duke contributed to a feeling that Duke's economic power would allow it to take over. Duke's wealth coexists with a sizable poor and underinsured population and limited access to care for many county residents. This dynamic can strain collaborative efforts.

However, work by the past and current Chancellors and CEOs of Duke University Health System attempting to address this tension strengthened health partnerships in the county. Key to this effort was the shared leadership of two trusted individuals. The Chair of the Durham County Commissioners (MaryAnn Black, a social worker by training) was hired to be the Associate Vice President for Community Relations for Duke University Health System in 2002. The community's trust in this commissioner when she led the Results-Based Accountability health committee along with the current Public Health Director, Gayle Harris, was critical to engaging other community leaders. Currently, the committees are chaired by leaders from Duke (Kimberly Monroe, Gwen Murphy, Mark Sullivan), Project Access (Sally Wilson), DCoDPH (Monica Curry), Alliance Behavioral Health Care (Jennifer Meade), and the East Durham Children's Initiative (David Reese, Jen McDuffie). Durham has benefitted from the generosity and collaboration of these leaders.

These collaborations have resulted in sustainable, long-term successes which demonstrate the benefits of collaboration. In 1995, the Principal of Watts Elementary School made a demand: Watts Elementary needed a school-based clinic, and the County and Hospitals were rich enough to provide it. Duke University Medical System joined hands with the (then county-owned) Durham Regional Hospital to create the first school-based clinic in Durham. Duke and DCoDPH continue to collaborate to offer clinical services in Durham Public Schools. The annual Durham Health Summit generated a collaboration between local groups -- the Partnership for a Healthy Durham, Durham Health Partners, Durham CAN (Congregations, Associations, and Neighborhoods), and the Latino Community Credit Union -- with Duke University Health System and Durham County, to develop a project to improve access to specialty medical care. Duke University Health System, Durham County, and Blue Cross Blue Shield became major funders. Built on commitments by Duke and community clinicians to offer donated care, Project Access of Durham County was launched in 2008 to link patients to transportation, case management, and donated specialty care. The project has expanded in 2013 to offer dental screenings and link adults to donated dental care.

DCoDPH and Lincoln Community Health Center cooperate to offer care to uninsured and underinsured Durham County residents, and both play an important role in addressing problems that disproportionately affect vulnerable populations. This could result in competitive tension. However, rather than competing, the administrations of the two organizations work together to use resources most effectively. For example, the organizations collaborate to offer services to women and children. DCoDPH offers obstetric care while Lincoln offers gynecology and HIV care services. Lincoln clinicians providing these services are located at both DCoDPH and at Lincoln. DCoDPH contributes space and infrastructure to Lincoln staff, and county residents benefit by being able to access services in convenient locations. Supplemental Nutrition Services for Women, Infants, and Children (WIC) services

are offered both at Lincoln (where family clinical care is offered) and at DCoDPH (where obstetric care, family planning, and pediatric dental care can be accessed), again allowing residents to access these services where it is most convenient, and thereby sustainably increasing access to care.

These organizations collaborated with Duke to address the low level of dental care received by children in Durham by establishing the Tooth Ferry, a mobile dental clinic which provides care at elementary schools. DCoDPH is responsible for clinical care and laboratory services. Funding to purchase the van and infrastructure support come from Duke Community Medicine. Durham Public Schools provides power to the parked clinic, the receptionist, and flexibility in the school schedule to allow children to attend appointments. The result of this collaboration is increased dental care for the county's poorest children.

In the Partnership Access to Care committee, where leaders from many organizations are consistent members, these relationships are strengthened. The most recent example of this is a collaborative decision to use federal Affordable Care Act resources received by Lincoln to hire health navigators and counselors and house them in organizations across the county, so that residents can receive help accessing health insurance many different organizations. In these examples, the power of leaders is harnessed for the good of the community.

Conclusion: Information plus relationships equals sustained improvements in health and health care

Durham's vibrantly diverse community has a history of both faith-based and politically-oriented community organizing. This history and the strong social commitment of many of the county's residents have succeeded in harnessing the collective power of leaders, partners, and community members to address community priorities. In 2013, Durham County has ongoing projects that link health-related organizations and agencies with the community, and allow for integration of community-based efforts, public health, and clinical services including primary care. The Durham community has created a vibrant, functional kettle in which to brew community partnerships. We're relying on shared information and our collaborative relationships to build effective public health programs and improve population health.

The quality of these efforts is demonstrated by national recognition. Collaborative health efforts in Durham have been highlighted in an Institute of Medicine report on the integration of public health and primary care (for example, Durham Heath Innovations), published in the scientific literature (for example, Senior PharmAssist), and have been recognized by a meeting with Michelle Obama (the East Durham Children's Initiative).

More importantly, county health status has improved. The rate of violent crime in Durham has decreased from 936 events per 100,000 in 2002 to 734 in 2011. Durham's early syphilis rate decreased by two-thirds between 2002 and 2011, from 24 to 9 cases per 100,000. Arrests for violations related to substance abuse (for various drugs) declined between 2009 and 2011; the proportion of middle school students reporting drug use also decreased steadily during these years. In 2013, county health rankings data show that the teen birth rate, preventable hospital stays, and the proportion of adults who smoke have decreased for each of the past 4 years for which data are available. Finally, our years of potential life lost to premature death have decreased every year for the past 4 years of data available. While important health challenges remain, we are proud of these successes, and of the collective strategies used to achieve them.