Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

PRIMER/BRIEF

Improving Health Care Quality and Equity: Considerations for Building Partnerships Between Provider Practices and Community Organizations

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Executive Summary

Provider practices juggling diverse patient needs and overbooked appointment rosters typically lack time to address the significant social, economic, and environmental barriers standing in the way of their patients' health. Given the day-to-day hurdles many patients face, including poor housing, lack of transportation, low health literacy, and healthy food scarcity, practices can benefit from strategic partnerships with local organizations whose mission it is to help meet these needs. Such entities can in turn help practices better understand local resources and socio-cultural preferences, gain trust of patients and families, and serve as a referral service for much-needed supports. This brief, originally written for practices participating in the Equity Improvement Initiative of the Robert Wood Johnson Foundation's *Aligning Forces for Quality* (AF4Q) national initiative, outlines considerations for practices looking to develop partnerships with community organizations.

This paper examines four critical components for building partnerships and key considerations for each. These components include:

1. Making the case for partnerships from the practice, patient, and community perspectives;
2. A framework and examples of partnership arrangements between practices and community entities;
3. Building blocks and activities to develop successful partnerships; and
4. Levers for sustaining practice-community partnerships.

The content for the brief was developed with input from national experts in the areas of practice improvement, disparities, safety-net systems, and community engagement (see acknowledgements). This paper mainly addresses practices that may have limited experience with community engagement but that seek to form relationships that can help them improve the quality or equity of their care. While there are several suggestions in this document, the paper recognizes not all are feasible given practices' competing organizational priorities, constraints on staff time, and lack of internal capacity; this may be particularly true for smaller, under-resourced, or independent practices. Thus, this brief is

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/goto/quality-equality.

About the Author

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not meant to be overly prescriptive, but rather, to serve as a reference to help practices understand how community partnerships may in fact help them advance their existing quality improvement goals and, additionally, the kinds of elements required to bring those relationships to fruition. The key guidance for practices around partnership foundation building, development, and maintenance can be summarized as follows:

Dig deep with patients. Reaching out to the community begins with reaching out to patients. Going beyond clinical symptoms to understand patients' motivations, fears, and personal challenges can uncover root causes of illness, shed light on trends across patients, and reveal underlying structural barriers in the community. Practices that systematically elicit such patient feedback, while being sensitive to cultural and linguistic patient preferences, are likely to develop trusting relationships with patients and, by extension, informed, meaningful interactions with future community partners.

Take concerted steps to understand the community. Practices can look to population-level data sources such as census and vital records, engage in conversations with local leaders who have knowledge of key social and historical issues, and solicit community feedback through focus groups and neighborhood meetings to improve their understanding of the community. Practices also can join, or borrow resources from, the existing efforts of public health departments or regional planning entities with the turf, capacity, and expertise to conduct activities such as community needs assessments.

Build on a strong internal commitment. Community partnerships require a strong sense of purpose from practice leadership and staff. Leaders are key ambassadors who set the tone across partner organizations, while staff require protected time and resources to commit to partnership-building. Organizations that sense a practice's strong internal commitment to community welfare are more likely to embrace partnership opportunities.

Develop a spirit of trust. Clinicians and community entities may have differences in scope of expertise, work ethic, and communication norms, but power conflicts in partnerships can be avoided by building a foundation of respect. Being transparent about goals early on, discussing strengths and needs openly, rotating leadership and convening roles, and admitting that "we have come to learn" will help practices build trust with organizations they might not otherwise have experience with.

Identify aims that are mutually agreeable, measurable, and actionable. Partnership goals should be set collaboratively among partners, keeping in mind the desired impacts for the practice, partner organizations, patients, and larger community. Creating a work plan with clear deliverables, accountable individuals, and measurable milestones for mid-course correction will help the partners be realistic about their targets and more likely to achieve them.

Institutionalize supports in the practice to maintain engagement. Evaluation tools and data metrics can help the practice operationalize partnership activities, while internal staff champions—particularly those who work closely with families and neighborhoods, such as community health workers—can provide longevity as sustained liaisons to the community. Other vehicles such as community advisory boards and patient leadership boards can offer systematic feedback to the practice, helping the partnership respond to changing community conditions.

Celebrate partnership successes. Affirming and disseminating information about partnerships can be instrumental in furthering their impact. Media coverage can help advertise "small wins" and gain stakeholder buy-in. Publicly reported improvements in performance data also can impress practice leadership, external funders, and policy-makers, creating a potential business case for sustained investment. Personal anecdotes from patients and families can make for some of the most compelling testaments to a partnership and serve as tipping points for broader change in the community.

Secure resources. Sustaining partnerships can require significant capacity building within and across partner organizations. Grants and other funds that prioritize investigation into social determinants of health, include requirements around organizational collaboration, or have flexibility with timeframes and deliverables are key supports for practices and their partners. Health care collaborators also can look to several other resources, including federal and state programs, public health agencies, health plans, employers, foundations, fundraisers, and local health initiatives, such as AF4Q.

Practice-community partnerships come in many shapes and sizes but are fundamentally built on organizations' mutual desires to improve the health and wellness of patient communities. Practices naturally will be guided by their quality

and equity goals and resource constraints, but the collaboration can benefit all partners and attain a larger community purpose when comprised of humility, pragmatism, committed participation, and strategic sources of sustainability. Ultimately, partnerships can be a game-changing tool used by practices and the community to address the common barriers that get in the way of a better and more equitable health care system.

I. Background

As many as 85 percent of primary care physicians (PCPs) feel that to achieve good health outcomes, it is as important to address patients' resource and social constraints as it is to treat their medical conditions.[i] Yet, the traditional medical system is not designed to meet the full array of patient needs. Factors that often have the most significant impact on health—the environments in which individuals live, work, and play and their behaviors—are outside of the traditional clinical care system.[ii,iii]

Practices looking to explore this new territory do not need go at it alone. Research has shown that barriers to patient engagement can be overcome by reaching beyond the practice's walls to create community partnerships.[iv,v,vi] Through effective practice-community links, unhealthy patient behaviors, such as tobacco use and poor diet, can improve.[vii] Community organizations bring valuable familiarity with patients' families and neighborhoods, but they may lack the clinical expertise to address chronic disease management, rehabilitation, wellness, and other medical complexities facing their community members. By bringing clinical and non-clinical partners together, partnerships can effectively link practices, patients, and the larger community and ultimately bring strength to the health of an entire region.

At the national, state, and local levels, emerging delivery system models leverage provider-community partnerships with the goal of improved health outcomes. Many of the Affordable Care Act's (ACA) payment and delivery system reforms—accountable care organizations, health homes, community health teams, and primary care extension hubs—provide incentives for practices to better address patient needs outside the clinic walls and, by extension, the health of the broader community. These new models require practices to improve prevention and complex care management through patient-centered approaches and develop community links.[viii] The Center for Medicare and Medicaid Innovation (CMMI) has created local and statewide funding opportunities, such as the Healthcare Innovation Awards and the State Innovation Models, to test delivery and payment models that use multi-payer and population health approaches to improve the quality of care and control costs. Multi-stakeholder health collaboratives, such as the 16 *Aligning Forces for Quality* alliances funded by the Robert Wood Johnson Foundation, are bringing together local providers, community organizations,

Examples of Policy Levers for Building Community Partnerships

National health policy stakeholders are increasingly acknowledging the importance of community partnerships in building practice capacity to deliver high-quality, culturally competent, and patient-centered care. The following criteria from the Affordable Care Act (ACA) as well as the Centers for Medicaid & Medicare Services (CMS), National Committee for Quality Assurance (NCQA), National Quality Forum (NQF), and Office of Minority Health (OMH) are advancing opportunities to incorporate community partnerships into practice infrastructure.

- **Health Home Requirements, Section 2703 of the Affordable Care Act**: Referrals to community and social support services are one of the six reimbursable health home services for Medicaid beneficiaries with complex and chronic conditions.
- **NCQA Patient-Centered Medical Home (PCMH) Certification:** Requirements include referrals to community resources, resource lists for key community services for patients, tracking of community referrals, and opportunities for health education and peer support.[1]
- **Community-Based Care Transitions Program, Section 3026 of the Affordable Care Act**: Eligible community-based organizations must provide care transition services across the continuum of care and have formal relationships with acute care hospitals and other downstream providers to reduce readmissions for high-risk Medicare beneficiaries.
- **NQF Cultural Competence Preferred Practices:** Recommendations include engaging communities to ensure that health care providers (individual and organizational) are aware of patient needs and relevant resources, collaborating with the community to implement programs that address culturally diverse populations and health disparities in the community and engaging communities in building resources to improve health outcomes.[2]
- **OMH's Culturally and Linguistically Appropriate Services (CLAS) Standards:** Requirements include ensuring staff receive ongoing training in culturally and linguistically appropriate service delivery and develop collaborative partnerships with communities and patients in designing CLAS-related activities.[3]

Sources:
(1) See sections 4B, 4B1, 4B2, and 4B4 of the 2011 NCQA PCMH Standards and Guidelines. This document can be accessed for free by registering on NCQA's website, and ordering the electronic publication, at: http://www.ncqa.org/PublicationsProducts/RecognitionProducts/PCMHPublications.aspx
(2) [1] See Preferred Practices 31, 32 and 34, in the NCF *Comprehensive Framework for Cultural Competency,* available at: http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_Preferred_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx
(3) See CLAS Standards 3 and 12 of the OMH, available at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

patients, and payers to undertake collaborative activities to improve health at a regional level. Public health departments also are increasingly partnering with Community Health Centers, Federally Qualified Health Centers, and other clinical system partners to create community interventions, incentivized by ACA provisions—programs such as the CDC's Community Transformation grants and recent Public Health Accreditation Board requirements.[ix,x,xi] The policy environment is thus ripe for practices to engage the community concertedly by joining collaborative activities of their public health and neighborhood comrades, building partnerships with new organizations, and ultimately, more fully engaging patients in their health (see sidebar).

II. Benefits of Developing Community Partnerships

Throughout this brief, "partnership" is used to describe a mutually beneficial relationship between a practice and a community organization. Practices are primarily concerned with enhancing health care quality, lowering costs, and improving patient satisfaction while recognizing that personal and community factors, such as low health literacy, financial instability, or environmental hazards, are key determinants of these outcomes. Community organizations are similarly interested in improving health and other social outcomes of their members but depend on clinical entities that can provide affordable, appropriate, and high-quality services. Partnerships are an opportunity for practices and community organizations to identify shared goals, uncover gaps, and join forces to achieve improved health care and quality of life for individuals in their communities. Depending on the target and scope of the collaboration, these partnerships can result in a number of specific and broad benefits for the practice, patients, partners, and the larger community. Examples include the following:

Benefits to Practices

- Access to community networks that can facilitate easier links to and greater patient use of critical supportive services;
- Enhanced local reputation and increased market share;
- Improved patient health literacy, uptake of preventive services, and responsiveness to care plans, reducing reliance on emergency room visits and patient safety or medication errors;
- Better care transitions across settings, and reduction of lengthy, high-cost inpatient stays and rates of re-admission;
- Enhanced cultural understanding among practice staff, and improved patient and staff satisfaction;
- Reduced disparities in care across racial, ethnic, linguistic, geographic, or socio-economic groups;
- Improvements in performance measures of access, outcome, and satisfaction;
- Access to community health and demographic data for benchmarking; and
- Opportunities to participate in broad health advocacy and policy activities.

Benefits to Patients

- Greater access to supportive services, including Medicaid, food stamps, housing, transportation, and employment;
- Increased trust of the practice and better experience of care;
- Increased support from patients' families, cultural peer groups, and communities in addressing and pursuing healthy behaviors;
- Enhanced convenience with services delivered closer to home, in a more comfortable setting, or at flexible times; and
- Better health outcomes and reduced specialty, inpatient, and emergency department visits.

Benefits to the Community

- Lower prevalence of disease and disability;
- Decreases in health costs and lost productivity;
- Better coordination among clinical care and public and community health efforts;
- Improved outcomes for racially, ethnically, and linguistically diverse populations; and
- Enhanced community cohesion.

Identifying a strong business case can be a powerful motivator for practices, as it can help acquire the necessary buy-in from internal leadership, funders, and key stakeholders. In addition to facilitating services and supports that may improve care quality, outcomes, or costs, partnerships also can increase a practice's patient loyalty, overall reputation, market knowledge and consumer base. Partnerships have been shown to improve practices' bottom lines, but a strict cost-benefit analysis is more complicated due to the collaborative nature and variety in the scope of partnerships.[xii]

A Clinic Partnership to Address the Needs of High-Risk, Homeless Patients

Clinica Family Health Services, a federally qualified health center in Denver, CO, is a safety-net provider for 40,000 patients, including 60 percent who speak Spanish exclusively and a large number who are uninsured or on Medicaid. In 2009, Clinica decided to focus on high-risk patients who face socioeconomic hurdles obstructing high-quality care. Many of these patients were homeless and in chronic need of housing, food, and other basic amenities. Clinica partnered with local community organizations to establish a medical respite program for homeless patients. The program facilitates reduced-rate rooms at local hotels, daily nurse visits, food deliveries from the "Meals on Wheels" program, and a social worker to coordinate services when patients are discharged from the hospital. The community-wide team, dubbed the "Complex Client Cross-Continuum," meets regularly for case reviews of complex patients. As a result of the partnership, a high-risk, homeless patient at Clinica signs a single consent form and is connected to a range of essential economic and social supports available in the community.

Practices looking to make a case for partnerships will be most successful if they align the partnership's purpose with their existing priorities and programs. For example, a practice working toward patient-centered medical home certification may pursue connections that help it create the mandatory referral lists for community resources. Independent or smaller practices looking to join an accountable care organization (ACO) may need to develop links with social service providers across a broad geographic area. Practices looking to become eligible for pay-for-performance incentives may find that partnerships can improve patient access to clinic services and self-management of conditions, and thus lead to better quality scores. Practices overwhelmed by issues such as electronic medical record implementation, data collection and reporting obligations, or the daily grind of managing high-volume patient flow, may find that partnerships relieve some administrative burden, for example, practices can borrow space from partner sites to host services or events; partners can serve as "staff extenders" in helping to educate patients or conduct outreach sessions; partners can assist with data retrieval or analysis; partners can develop marketing materials to help advertise clinic services; or partners can provide in-kind resources such as computers, books, art, or gift certificates that may help existing efforts, such as office renovations, development of an onsite patient library, or a patient incentive program.

In thinking about the full impact of potential partnerships, practices must consider the benefits for the partner organizations as well. Collaborations will be effective only when they bear fruit for all organizations involved and are approached with a team mindset. Practices also may learn that ultimately it is the intangible, unpredictable factors such as the working style and mutual respect of partners, or political circumstances, that make or break the collaboration. Practices should thus ultimately make the "case" for partnership not in isolation, but in consideration of the shared goals, expectations, and resource capacities of the partners.

III. What do Practice-Community Partnerships Look Like?

There are many types of partnerships that can be fruitful between provider practices and community organizations.[xiii,xiv] The decision to enter into a partnership and the subsequent structure depend on the goals of the practice. Meeting these goals may require developing ties with a single new organization, creating a larger partnership across multiple entities, or joining the broad effort of an existing community program. Considerations for the practice in distilling whether and what kind of partnership to pursue include:

- Resources, skills, or knowledge necessary for the practice to meet its goals;

- Availability of existing community or health networks;
- The types of partner organizations best suited to help fill gaps in practice strength; and
- The amount of investment the practice can make in the collaboration.

Types of Partnerships

A practice's approach to these variable considerations also may depend on the level at which the practice seeks to make an impact. Following are three types or "levels" of partnership and examples of activities to reach practice/community objectives for each:

- ***Patient/Practice:*** This level of partnership provides direct supports to individual patients to: (1) increase access to a particular service, (2) enhance patient knowledge, or (3) motivate positive health behavior. Patient supports are generally provided on-site by the practice, at the partner organization's site, or in the patient's residence. These may be most ideal for a practice's highest-risk patients (see sidebar). Following are examples of partnership objectives and activities:
    - **Use care transitions to reduce preventable emergency department use and costly hospital readmissions**. The practice recruits a set of community health workers, trained by a partner local health education agency, to help high-utilizing patients make the transition from discharge to outpatient care to their homes. The community health workers monitor patients' progress in self-management activities and help them link them to necessary housing, transportation, and employment resources.
    - **Reduce no-show rates and medication errors among older patients.** The practice partners with a local senior center and a pharmacy to provide flexible transportation services for or any elder or frail patient requiring assistance as well as medication management assistance on-site after an appointment.
    - **Improve appointment scheduling and patient-staff communication for new immigrant patients, many of whom have limited English proficiency**. The practice partners with a community health access coalition, a Hispanic/Latino advocacy group, and an Asian community center to set up language access lines for phone interpretation and translation of health education materials into multiple South American and Asian languages.
- ***Population/Neighborhood:*** Partnership activities at this level can impact a broader swath of individuals or issues, beyond a discreet set of patients, for example, all diabetics in a neighborhood or members of a particular racial/ethnic group. The activity may be performed on-site, at the partner organization's site, in a particular neighborhood, or at various community locations. Following are examples of partnership objectives and activities:
    - **Increase HbA1c testing and glucose control rates among the African-American patient population in an underserved part of the city.** The practice partners with an urban African-American men's league, the local chapter of the American Diabetes Association, and a popular city church to host cooking classes, physician meet-and-greets, and free testing camps on church premises.
    - **Respond to difficulties facing families of child patients with serious behavioral health challenges**. A practice serves as a clinical advisor for a System of Care initiative involving a mental health advocacy group, local parent-teacher association, and community mental health clinic to educate caregivers about essential medical services such as immunizations, well-child visits, and BMI assessments.
    - **Improve frequency of prenatal care visits and birth outcomes to meet quality milestones set by the state Medicaid program's maternal and child health initiative.** A practice collaborates with the local Women, Infants, and Children (WIC) program and a social media non-profit to create an informational online blog for pregnant and young mothers who participate in home-visiting programs to share recommendations and personal experiences with other women.
- ***Community/Outreach:*** This level of partnership benefits communities across a geographical area. This partnership may be led directed at service delivery and more focused on communicating about medical, public health, or policy issues; coordinating community resources; or advocating for particular causes. This approach

may be more feasible for large practices with broad catchment areas and larger capacity. Following are examples of partnership objectives and activities:

- **Respond to public anxiety around a recent flu outbreak**. A practice partners with a county public health department, a social marketing firm, and a Spanish radio station to create a media campaign promoting vaccinations.
- **Respond to a new initiative created by the mayor and observed increases in avoidable ED visits by young children.** A practice participates in regular meetings with urban planners, public health departments, environmental safety experts, and patient advocates to discuss the effect of a local manufacturing plant on high child asthma rates.
- **Respond to the practice leadership's strategic focus on health equity**. A practice forms a community advisory board, including cultural organizations, local employers, social service agency, and public health department dedicated to addressing health barriers facing communities of color in the region.

Practices have a broad swath of community resources to think about in identifying what partnership opportunities will best suit the diverse needs of their patients (see sidebar). Successful partnerships will be effective when they capitalize on the unique strengths and mission of each participating organization while working toward a mutually agreed-upon aim.

Partnership Activities

Partnership activities vary widely and range from providing one-time supports or intermittent referrals to in-depth relationships that change the path of care delivery. In thinking about what specific arrangements might look like among organizations of interest, it may be useful for practices and their partners to review the following examples:[xv]

Conduit: Allow organizations to use each other as vehicles to share important resources.

- *Example: A practice joins an existing partnership between a local health coalition and retailers, wherein hair salons, grocery bodegas, and malls in a predominantly African-American neighborhood are given culturally specific diabetes self-management materials to distribute to their customers. An employment services and supportive housing agency looks to a practice as a referral source to increase uptake of its services.*

Technical Assistance: Facilitate the spread of key competencies between organizations.

- *Example: Providers and administrative staff receive training in motivational interviewing, behavior change curriculum development, and cultural competency from a local area health education center (AHEC) and HIV/AIDS community health center. A practice works with a social media firm to design e-health patient portals using computers donated by a local church. A popular gymnasium asks a practice to review its clinical visual aids and coach its fitness trainers for a new healthy eating and physical activity program.*

Capacity Builder/Community Organizer: Build long-term infrastructure for health care within the broader community.

- *Example: A rural practice works with the major industrial employer and the county health department to set up mobile screening vans at the employer's various worksites and the key village centers. A practice provides*

Examples of Potential Partner Organizations

- ***Community/Culture:*** Racial/ethnic/language-affiliated organizations, religious/spiritual, interfaith associations, aging and disability centers, youth recreation centers, LGBT centers, sports/fitness organizations, consumer advocacy organizations.

- ***Economic Support:*** Food stamp or Medicaid enrollment agencies, supportive housing, food kitchens, homeless shelters, transportation services.

- ***Public Local and State Agencies:*** Medicaid, public health, mental health and substance use, regional/urban planning, education, environmental health and safety, parks and recreation, family services, child welfare, criminal justice systems.

- ***Other:*** Employers, health professionals and associations, educational institutions, quality improvement and practice support organizations, labor groups, retailers, media outlets.

information on its uninsured patients to local promotores, who, along with a social justice coalition, lead a campaign to enroll eligible, but enrolled, low-income families in Medicaid.

Advocate: Help advance policies that support the constituents of one or both organizations.

- *Example: A physician champion makes a presentation at a fundraiser for an Asian-American cultural organization to increase awareness about the burden of hepatitis C and colorectal cancer in the community. A group of physicians speak at a local city hearing to advocate for more walkable spaces and parks and fewer fast food chains in a poor neighborhood with high rates of obesity. A practice secures foundation funding to launch electronic health records due to support letters from leaders of local community organizations.*

These examples provide just a glimpse at the many possibilities for shaping community-practice partnerships. The roles of practice and community partners are not exhaustive, nor are they mutually exclusive: The practice and partner organizations may serve multiple functions within one working relationship. Over time, roles also can evolve from high- to low-touch, or vice versa, as partners gain familiarity in their working relationship or as partnership needs change.

IV. How do Practices Develop Community Partnerships?

Effective partnerships rest on key building blocks, such as engaged leadership and staff buy-in, collaborative planning and goal-setting activities with partners, and continued community input and resource allocation to ensure sustainability.

A. Building Blocks

Below are fundamental components to help practices pursue a community-focused mindset and prepare for meaningful engagement with external entities.

Start with patients and dig deep. In addition to a patient's medical history, practices need to understand how other aspects of his or her life—such as family makeup, personal goals, fears, or neighborhood conditions—affect health outcomes. Building trust with patients can lead to conversations that reveal barriers to healthy practices, such as lack of child care, substandard housing, or lack of motivation. Such rapport can be hard to build in 15-minute appointments with physicians, but practices can use the diverse strengths and observations of staff personnel—including nurse care managers, medical assistants, and patient navigators—to build this internal capacity. Staff may need some training in motivational interviewing and other communication techniques to facilitate these interactions with patients. As a step to becoming more patient-centered, practices also can seek to include peer specialists or patient representatives who can provide clinicians and other staff with first-hand, experiential feedback to improve care delivery (see sidebar).

Take steps to understand the community. Practices admittedly know less about population health needs than they do practice-level quality outcomes, but there are many vehicles through which they can develop knowledge about the community conditions affecting their patients (see sidebar). Practices, particularly smaller ones, likely do not have the bandwidth to conduct large-scale assessments, but they can contact their local public health departments to acquire such data. Non-profit hospitals and other larger providers in the area might be good resources, as they are increasingly conducting community needs assessments as part of their community benefit programs and in response to ACA mandates. Practices can additionally look at community-based participatory research findings, publicly available provider reports, or community data dashboards that multi-sector collaboratives,

Integrating Patient Voice in Care

Humboldt Del-Norte Independent Practice Association (IPA) and Community Health Alliance, a community-based, consumer-driven nonprofit, have been leading consumer engagement efforts of the Aligning Forces for Quality program in Humboldt County, CA. Over the past two years, these organizations have been working together to respond to the increasing complaints from consumers that they feel disconnected from the medical care system and analogous reports from practice staff that they are unable to engage patients sufficiently. In response, they embedded "patient partners" in 18 practices that were participating in a primary care quality improvement program. Each practice was required to select and support a patient to participate on the medical office team and continuously offer the patient perspective. While there have been some challenges related to integrating the patient partners into workflow, the IPA and Community Health Alliance have reported enhancements in internal quality improvement protocols and in process and clinical outcomes across the participating practices. Practices acknowledged that the patient partners have laid the foundation for a cultural shift in the way the practice views quality improvement and patient engagement.

such as *Aligning Forces for Quality*, might already be using for their improvement activities. These data points may help practices understand instances of illness in the clinic as part of a local trend, rather than isolated events. Community data can further help the practice benchmark its own performance and understand root causes for evident gaps, particularly if the practice has quality data stratified by race, ethnicity, language, geography, or socio-economic status.

Build on dedicated leadership. Community partnerships require a strong foundation of commitment from leaders of the practice and partner organizations. Such buy-in will help ensure partnership activities receive the appropriate internal time, resources, and attention from practice staff. Leaders who demonstrate humility and an openness to collaborate will be more likely to receive positive signals from leaders of partner organizations in initial conversations. Similar characteristics also will help resolve conflicts of turf, power, and resource allocation that may come up through the course of the partnership. Finding external leaders in the community to serve as boundary spanners among organizations also help the practice learn about local cultural and political realities, facilitate negotiations with new partners, and find common ground.

Foster staff engagement. Productive partnerships require staff who feel committed to community engagement and are willing to create the necessary operational infrastructure. While clinicians and frontline staff may consider advocacy for an individual patient an accepted and ethical part of their professional practice, they may not naturally take the next step to see the community as their patient or advocate for change at community level. Practices can build this orientation by engaging personnel in discussions about community conditions through focus groups or staff surveys and cultivating internal camaraderie through cultural competency and team-building seminars. Opportunities that build a culture of openness and equity within the practice will help staff develop the skills to communicate sensitively with analogous members of partner organizations as well. Some practice staff members also can be incentivized to join community health boards or volunteer with organizations such as Medical Reserve Corps, Red Cross, or United Way to help build their orientation to community realities as well.

B. Partnership Development Activities

With the right infrastructure in place, practices can identify community partners and jointly establish partnership goals and protocols. Practices and their partners can benefit from approaches like the SMART framework to create partnership arrangements that are specific, measureable, appropriate, realistic, and time-framed.[xvi] Following are activities to help cement effective practice-community relationships.

Identify shared goals and actionable strategies. It is essential that the practice and community partners have a transparent discussion about the aims of the partnership. Once they determine their shared goals, they should document strategies, establish a coordinated work plan, and assign

Understanding Patient Communities

Taking steps to understand community needs can increase a practice's understanding of which resources will be useful to improving patient outcomes as well as broader community priorities. Following are activities that practices can pursue:

- Acquire data on patient and communities through: (1) state and local public health sources (e.g., vital records, surveillance and monitoring data.); (2) county health rankings;[1] (3) census data; and (4) geographical information system tools.
- Meet with community members who can identify critical issues. These may include school personnel, local business leaders, cultural or religious leaders, and neighborhood coalition members.
- Find a boundary spanner. Identify one or two individuals with the credibility, knowledge, and enthusiasm to champion the practice's community outreach efforts. They can help in facilitating conversations with future community partners as well.
- Scan local newspapers, neighborhood newsletters, public bulletin boards (e.g., in libraries, community centers) and culturally specific news media to understand local priorities and current events. Digital storytelling archives or photovoice projects can also provide powerful information about a community's needs.
- Find out if the community has a "community health improvement plan" developed by local authorities and neighborhoods for public health accreditation or for community benefits planning. Such plans usually have extensive information about local health needs.

Sources:
(1) County health rankings available at: http://www.countyhealthrankings.org/

"The first step is convincing community organizations that everything is in place on the clinic's end, that the clinic staff are going to do everything possible to make the relationship work."

— Chief Medical Officer, Community Health Provider Network

responsible lead personnel across all partners. Flexibility is also important, as approaches may evolve over time. For example, the original milestones may not be reachable, particular interventions may fail, or local politics or changing priorities may alter organizational dynamics across partners.

Develop mutual trust. Partners must create a relationship that fosters mutual respect and trust. Those leading initial collaborative sessions should acknowledge perceived imbalances in power and adjust expectations accordingly to bridge organizational differences. As a practice looks to build relationships with different community partners, it should tailor its approach to each, as necessary. For example, a particular ethnic community may not be comfortable with certain communication norms, or some organizations may be former competitors and less natural collaborators.

Practices can use the following strategies to maintain respect and balance in authority within partnership activities:

- Take time at initial meetings to share the history and structure of each organization;
- Rotate leadership, hosting, and convening roles;
- Simplify language to avoid use of field-specific jargon;
- Adjust formality, communication protocol, and work ethic expectations to bridge organizational differences in culture;
- Convene in-person meetings to build interpersonal relations and hold each organization accountable;
- Conduct site visits to familiarize each organization with the other's mode of operation; and
- Find ways to build camaraderie through social activities and celebrations of achievements.

Establish milestones to assess partnership progress. Although it may be difficult to measure all variables that factor into practice-community partnerships, practices might consider establishing a few milestones to guide partnership activities from the start. As measurement can take significant time and resources, partners should focus on metrics that are easily measurable and actionable so more energy is spent in implementing, rather than planning. Measures will be useful when they help the organizations gauge the degree to which the partnership is achieving the intended aim and allow course correction as necessary. The following questions can help guide the development of milestones:

- What do the partners expect to receive from the partnership?
- What are some proxies for partnership success?
- How is the partnership expected to impact both patients and the larger community?
- What red flags would indicate that the partnership is not going down the right path?
- What are the best care and worst case scenarios?
- What project management targets (e.g., staff, deadlines, resources, data) would be important to track along the way?

> *"There is no "right" way. Try the parts that make sense. If they work, keep going in that direction. If they don't work, try a different strategy."*
>
> — Chief Medical Officer, Community Health Provider Network

Many of these questions can be answered through informal conversations across participants. More formal data sources such as performance measures, regional health indicators, patient feedback surveys, and other tools may also be used for baseline- and milestone-level setting; using measures that are already available or being collected for other programs will reduce measurement burden and increase likelihood that the assessment work will get done. When possible, developing some impact measures to create a type of business case also can be a powerful hook for communicating value to internal leadership. Gathering personal narratives illustrating impact from patients, practices, partners, and community members also can paint a more nuanced picture useful for evaluation and strategic communication with stakeholders.

C. Sustainability

Sustaining a community partnership over time requires a practice and its partners to revisit its partnership structure, protocol, and intended outcomes, particularly in relation to staffing, community, and resource constraints. Following are steps practices can take to help ensure sustainability.

Maintain staff participation. Time constraints amidst day-to-day patient management can prevent practice staff from investing continuous energy into partnership activities. To maintain the perceived value internally, practices can integrate partnership activities into regular workflow, such as weekly meetings and work plans. Practices can consider identifying internal champions who are enthusiastic about community engagement and create permanent roles that give them formal purview over the partnership operations. Practices also can work with their community partners to identify strategies to keep staff from all organizations engaged, such as staff appreciation celebrations or group volunteer outings.

> *"While the partnership strategies often start with higher leadership, it quickly boils down to 'who do I call.'"*
>
> – Executive Director, Statewide Health Advocacy Agency

Create permanent vehicles for community and patient input. Community engagement requires the practice to keep a pulse on evolving patient needs and community conditions. A partnership that is not adaptable to such change will not be successful. Members of care teams that have a link to the community, such as community health workers, patient navigators, or peer specialists, can be an invaluable resource and help the practice relate its own challenges to community realities (see sidebar). Practices also can use their existing community advisory boards or patient committees—or work toward creating them—to gather feedback on programs, monitor changes in patient needs, address emerging disparities in care, or identify new partnership opportunities (see sidebar). Members of these committees often come from other sectors of the community, including education, public service, the arts, or local business and can thus also serve as goodwill ambassadors for the practice.

Disseminate partnership success stories. It is important to acknowledge the positive impact that the partnership is having on patients, the participating organizations, and the community at large. Media coverage, blogs, and newsletters can help spread information about the progress of partnerships and help gain community buy-in for future efforts. Publicly reported improvements in performance data can impress funders, leadership, and policymakers and create avenues for sustained resources. Personal anecdotes from patients, families, and community members also can tell a powerful story and be gratifying for the storytellers themselves.

Identify sources for funding and capacity building. Lack of sustained funding is a significant barrier to a partnership's staying power.[xvii] Finding sources that are diverse in scope, have program requirements that promote organizational collaboration, and are flexible with timeframes or deliverables will help. Following are examples of potential resources practices and their partners can tap into for direct funding or related supports:

Federal: Several federal agencies fund community-based efforts focused on improving equity, quality, and access to care:

- The **Centers for Disease Control and Prevention's** Healthy Communities Program[xviii],[xix] and Community Transformation Grants[x] offer funding for multi-sector collaborations at the local level as well as well as technical assistance around community health planning, disease screening, disparities, health literacy, communications, social

Asian Health Services: Sustaining Patient and Community Feedback

Asian Health Services (AHS) is a community health center in Oakland, CA. For almost 40 years, it has been serving the Asian Pacific Islander community. Nearly all its patients are below 200 percent of the federal poverty level, and they represent 10 different Asian languages, with 60 percent being Cantonese-speaking Chinese with limited English proficiency. To serve its diverse and low-income communities better, AHS established Patient Leadership Council (PLC) groups in Cantonese, Mandarin, Vietnamese, Korean, and Khmer (Cambodian) in 2005. Each PLC consists of 15-25 members, who work to improve the practice's ability to provide culturally and linguistically appropriate health care access for the Asian and Pacific Islander community. PLCs include community health workers who lead monthly leadership trainings and educational workshops with the patients and staff around peer health education and advocacy. The PLCs have created a sustainable mechanism for identifying both patient and community needs.

marketing, and workforce development.

- The **Health Resources and Services Administration** (HRSA) provides several grants and technical assistance resources to support federally qualified health centers (FQHCs), rural health centers, and other community-based providers. HRSA's HealthcareCommunities.org initiative disseminates best practices in community-based quality improvement.[xx]

- The **National Institutes for Health**, **Agency for Healthcare Research and Quality**, and **Office of Minority Health** offer resources and grants in the areas of: research, including disease-specific interventions and community-based participatory methods; performance measurement and quality improvement; and disparities reduction.[xxi,xxii,xxiii]

- The **Substance Abuse and Mental Health Services Administration** (SAMHSA) offers resources to help communities establish home- and community-based services for behavioral health, including peer and caregiver support.[xxiv]

> *"Our capacity for community partnerships really began as a result of our work with community behavioral health providers and federal and state behavioral health funding."*
>
> *—Executive Leader for Clinical Services, Federally Qualified Health Center*

- **Local Area Health Education Centers, Regional Extension Centers**, and **Beacon Communities**—all federally funded efforts—can provide local expertise and on-the-ground capacity building for workforce development and health information technology.

State: State Medicaid programs are increasingly seeking to support high-volume Medicaid practices in improving health outcomes and reducing unnecessary utilization. Examples of state programs that may be available to support practices include:[xxv]

- Paying practices for patient-centered medical home, health home, and accountable care organization activities; or

- Providing technical assistance to practices, such as learning collaborative, practice coaches, or training webinars, through multi-stakeholder statewide delivery reform initiatives, such as the State Innovation Model and meaningful use implementation grants.

State block grants and related funding programs in mental health, substance use, maternal and child health, family services, criminal justice, and education also are sources through which practices can receive support or participate as partners with public health agencies or community-based organizations that may be receiving these funds.

Health Care Collaboratives: These are vehicles through which practices can get direct support to work on key health care goals. State-led institutes and learning communities (e.g., California Maternal Quality Care Learning Collaborative) can be valuable sources of training, technical assistance, and peer learning. Regional efforts focused on community health improvement, such as Aligning Forces for Quality are naturally poised to support practices looking to build better networks in a community. Such programs convene key stakeholders such as providers, health plans, and consumers; centralize resources to address shared systemic issues; and create local solutions to health care gaps, making it easier for practices to learn about and align with the larger efforts of a region.

Public health agencies: Public health authorities are natural fits for partnership efforts, as community health is their top priority, and they often fund or work closely with community-based organizations.[xxvi,xxvii] They typically have experience in collaborating effectively with sectors such as urban planning, education, and environmental safety and thus can be key sources of technical assistance, data, and guidance for practices who may not be familiar with multi-sector work. Practices should approach existing public health efforts with an open spirit of collaboration, being mindful of potential turf issues and respecting institutions that have played a key historical or political role in community planning.

Health Plans: Health plans often fund community engagement programs to increase uptake of services, raise awareness of key health issues, and improve member health outcomes.[xxviii,xxix] They work closely with practices and other groups in the community to ensure the success of these efforts.

Employers: Employers often work with community organizations to coordinate health fairs, referrals for fitness, nutrition and smoking cessation counseling, and onsite screening and health education workshops.[xxx] Practices are well positioned to provide their clinical expertise and services in these efforts.

Foundations: National, state, and local philanthropies are significant funding sources for multi-stakeholder efforts that involve practices in community engagement. The Robert Wood Johnson Foundation, Annie E. Casey Foundation, W.K. Kellogg Foundation, and California HealthCare Foundation are just are just a few of the numerous foundations supporting health care improvements in communities across the country. Charitable arms of pharmaceutical firms, insurance companies, and retailers also are good sources of support for community engagement.

Fundraisers: Partnerships can hold fundraising events (such as bake sales, raffles, or charity auctions) by themselves or in collaboration with other local community bodies such as faith-based groups, neighborhood organizations, or other health care providers. Teaming up with reputable health institutions like the American Heart Association, United Way, or Red Cross also can help bring more community credibility to these events. While these may not be sustainable sources of income, they may help the partnership through more difficult financial situations and assist with strategic visibility.

VI. Conclusion

Provider practices increasingly recognize that the factors leading to quality health care outcomes extend far beyond the confines of a physician office. Partnerships between physician practices and community entities can help practices become a more dynamic participant in their patients' lives and find innovative ways to address issues beyond the typical reach of clinicians. Through such linkages, the partner organizations and the community at large also benefit from increased attention to accessibility, adequacy, and cultural specificity in health care services and enhanced supports for self-care. Partnerships can be effective in a number of forms: a practice may start a new collaboration with a single organization, develop a multi-level initiative across multiple entities, or join the larger efforts of an existing community-wide program. The quality and equity goals of the practice, the resources available to it, and importantly, the unique aims and needs of the partner organizations, will all shape the nature of the collaborative relationship. Ultimately, such partnerships, when built on mutual goals, respect, and a sustainable foundation, can change the face of health care delivery, accelerating improvements in care and well-being for low-income and diverse families throughout a community.

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