



ADDRESSING THE DETERMINANTS OF HEALTH TOGETHER:

A Resource Guide for Hospital-Community Collaboration

Dalla Lana School of Public Health,
University of Toronto



Dr. Blake Poland, Andrew Koch, Heather Graham, Saddaf Syed



**A RESOURCE GUIDE FOR
HOSPITAL-COMMUNITY
COLLABORATION:
Addressing the Determinants of Health Together**



**UNIVERSITY OF TORONTO
DALLA LANA SCHOOL OF PUBLIC HEALTH**

August 2008

Dr. Blake Poland

Andrew Koch

Heather Graham

Saddaf Syed

& members of the Hospital-Community Collaboration Knowledge Translation Project

Acknowledgements

The *Hospital-Community Collaboration Knowledge Translation* project is supported by a grant from the Change Foundation/Healthcare, Technology and Place Funding Alliance. Team members included Dr Blake Poland (Principal Investigator), Heather Graham (Consultant), Julie Gilbert (The Change Foundation), Catherine Maule & Saddaf Syed (Project Coordinators), Andrew Koch (Research Assistant), Heather Campbell (research/writing consultant), and Roshanak Mehdipanah (student volunteer). We would like to acknowledge the following Advisory Group members: Elaine Walsh, Anne-Marie Marcolin, Lorraine Purdon, Ted Mavor, Chris Rahim, Dan Clement, Karen Kuzmich, Joan Roberts, Adrianna Tetley and Russ Ford.

Much of this guide is based on original data collected as part of the *Hospital Involvement in Community Action* (HICA) research study. The HICA study was supported through funding received from a strategic initiative of the Social Sciences and Humanities Research Council of Canada (grant # 416537). The core research team comprised Blake Poland (Principal Investigator), Leslie Fell, Heather Graham, Janet Lum, Elaine Walsh, and Paul Williams. Marie Boutilier and Natasha Greenberg provided valuable assistance with the collection and analysis of qualitative case study data. Stasey Tobin and Saddaf Syed served as Project Coordinators during the course of the study. We wish to warmly thank all those who graciously participated in the study as interviewees and those who facilitated our entry and orientation in the case study sites.

We also wish to acknowledge the participation and insightful input of the individuals who participated in the focus testing of the draft resource guide and our partner organizations: Collaboration in Community Development (CCD), Canadian Council on Health Services Accreditation (CCHSA), Joint Centre of Excellence for Research on Immigration and Settlement – Toronto (CERIS), Canadian Healthcare Association (CHA), National Capital Alliance on Race Relations (NCARR), Ontario Hospital Association (OHA), and the South-east Toronto Organization (SETO). We also wish to acknowledge and thank the following collaborators: Robin Badgley, Josee Bourdages, Joan Feather, Georgia Bell Woodard, Beth Hoen, Joy Johnson, Ron Labonte, Ted Mavor, Jerry Mings, Robert Sigmond, Wilfreda Thurston, and consultant Trevor Hancock. We also wish to thank the Healthcare, Technology and Place/The Change Foundation Funding Alliance and the West End Urban Health Alliance (Toronto) for financial and in-kind assistance with knowledge translation. Special thanks to all those individuals in community and hospitals across Ontario who have contributed through their enthusiasm, critical feedback, and insightful comments to the ongoing evolution of this work, helping it to be the ‘living document’ that we always wished it would be. Please note that the ideas and content expressed in this report remain the sole responsibility of the authors and do not necessarily reflect the views of funders or contributors named above.

Table of Contents

I. Introduction.....	1
1.1 About this Guide.....	1
<i>Table 1: Simple, complicated and complex problems.....</i>	<i>2</i>
1.2 Note about the Research.....	3
II. Understanding Hospital-Community Collaboration.....	5
2.1 What is Community?	5
2.2 What is Hospital?.....	5
2.3 What is Collaboration?.....	7
2.4 What is Hospital-Community Collaboration?.....	8
2.5 Why Collaborate?.....	8
<i>Table 2: Examples of hospital-community collaborations.....</i>	<i>9</i>
<i>Health system developments that call for collaboration.....</i>	<i>10</i>
<i>What do hospitals have to offer?.....</i>	<i>11</i>
<i>Addressing broad determinants of health: A role for the health sector.....</i>	<i>12</i>
<i>Table 3: Where is your organization on this continuum?.....</i>	<i>13</i>
<i>Advice from the Field: Challenges and pitfalls.....</i>	<i>15</i>
2.6 Understanding Hospital and Community Cultures.....	15
<i>Table 4: Contrasting Organizational Perspectives and Modes of Practice.....</i>	<i>16</i>
<i>Figure 1: A Model of Hospital-Community Collaboration</i>	<i>17</i>
III. Taking Action.....	18
3.1 Using a Community Development Approach.....	18
<i>What community development is not.....</i>	<i>19</i>
<i>Table 5: Community Engagement: Assumptions and Reality.....</i>	<i>20</i>
3.2 How Organizations can Support Community Development Work.....	20
<i>How hospitals can build trustful relationships with community groups.....</i>	<i>22</i>
3.3 The Role of Champions.....	23
<i>Collaboration as invisible work.....</i>	<i>23</i>
3.4 Is your Organization Ready to Collaborate?.....	24
3.5 Developing Effective Collaborations.....	25
<i>Stages of developing a collaborative relationship.....</i>	<i>25</i>
<i>Suggestions for community organizations.....</i>	<i>26</i>
<i>Collaboration success factors.....</i>	<i>27</i>
<i>Working with diverse communities.....</i>	<i>28</i>
3.6 Evaluating Collaboration: How are we Doing?.....	20
3.7 Sustaining Collaboration.....	31
IV. Concluding Thoughts.....	32
V. Glossary	33
VI. References	35
VII. Appendicies	37
<i>A. Recommended Resources.....</i>	<i>38</i>
<i>B. Hospital Involvement in Community Action: Summary of research findings.....</i>	<i>40</i>
<i>C. ‘Social Determinants of Health: Why Do They Matter?’ (Fact Sheet)</i>	<i>42</i>
<i>D. Partnership principles checklist</i>	<i>45</i>
<i>E. Template for Partnership Agreements</i>	<i>46</i>
<i>F. Sample hospital policy on external partnerships</i>	<i>51</i>
<i>G. “Why Consider Diversity?” Fact Sheet</i>	<i>54</i>
<i>H. Tips for Evaluating Collaborative Initiatives</i>	<i>56</i>

I. Introduction

“Hospitals and Community need to work together.”

How many times have you heard this call for more collaboration between hospitals and community organizations to better meet the health care needs of the population and to address factors that affect community health? This may seem like a perfectly reasonable idea, but it also raises some important questions. For instance, under what circumstances are these collaborations useful and effective? What is the best way to go about starting a new collaboration or strengthening an existing one?

Collaboration involving hospitals and community groups is common. These efforts span a wide spectrum of issues, from the coordination of clinical care among healthcare providers to policy advocacy regarding broader determinants of community health. Collaboration builds upon the assets, strengths and capacities of communities and institutions to make programs and services more effective and responsive as well as to generate solutions to address complex health issues.

However, hospital-community collaboration (HCC) is often not easy or straightforward. The work of hospitals has traditionally focused on patient-oriented, clinical care; hospital staff are hired and trained with this focus in mind, rather than community development skills. Collaborating with community organizations on broader health issues often represents a departure from the hospital’s perceived core mandate. At the same time, community organizations may be reluctant to work with hospitals which they may see as large, bureaucratic organizations that do not share their culture or values. Also, there are few resources available to guide decision-making by hospital administrators, managers, front-line staff and community organizations on key issues such as when collaboration makes sense, who to work with, and how best to work with others.

1.1 About this guide

The guide builds on identified promising practices, facilitates critical thinking and reflection, and offers some practical tools & templates to support meaningful practice.

Sections of the guide include:

- Advice from people in the field
- Barriers to, and enablers of collaboration
- Hospital community collaboration promising practices (model and examples)
- The role of ‘champions’
- Partnership principles and readiness checklist
- Tips for facilitating, evaluating and sustaining effective collaborations
- Sample partnership agreements
- Things to consider when working with diverse communities
- Recommended resources

The guide can not only be used to reflect on and enhance existing practices, it can also be used to help assess or negotiate potential working relationships and make a case for hospital-community collaborations.

The guide was developed for:

- *Anyone involved in or contemplating hospital-community collaboration (HCC)*
- *Hospital staff* with a particular interest in starting or supporting HCC
- *Community organizations* contemplating or engaged in HCC
- *Policy makers* and LHIN staff with an interest in promoting and supporting HCC

- Those *experienced in HCC* (as a resource document or teaching tool for educating colleagues) *and those just starting out* (issues to consider, pitfalls to avoid, critical reflective questions to guide planning)

Furthermore, the guide can be used in various ways including:

- As a teaching tool, to educate others about hospital-community collaboration
- For personal development
- As a reference document (e.g. when writing proposals)
- To help make the case for collaboration
- As a source of specific tools (see Appendices)
- To identify and discuss values & collaborative process
- To plan for new collaborations
- To reflect on and evaluate existing collaborations
- As a source of critical reflective questions
- To learn from the experience of others

1.2 Background

This resource guide provides an overview of hospital-community collaboration and describes how it can be useful, as well as some of the success factors and challenges associated with this kind of work. The focus is on issues that are relevant to HCC in Ontario, especially those collaborations that address the determinants of health (the social and economic conditions that influence the health of individuals and populations - see Appendix C) outside of the hospital walls. It complements the many general resources available to assist you in developing effective interagency collaboration. We hope that it will be a helpful reference for hospital staff as well as community organizations that are planning or are currently involved in collaborative work with hospitals. The guide does not assume a great deal of experience in this area. However, we have tried to make it useful for more experienced practitioners as well as for readers who may be approaching this subject area for the first time.

It can be a challenge to write a single Guide for multiple audiences. We considered and rejected the idea of writing separate Guides for different audiences. Our community partners in particular told us they valued seeing what we were telling hospitals about this work. Our research was also based on a firm commitment to honour multiple perspectives and to include community perspectives on HCC. That said, we have found a receptive audience amongst hospital staff with a keen interest in collaborative work with the community. While the Guide is written very much with them in mind, we wanted to be sure to include something for everyone, in the spirit of promoting dialogue and sharing perspectives. The enthusiasm for the Guide that we encountered in the community during our focus testing of the initial draft confirmed the wisdom of our approach, as well as the challenges associated with it.

We are mindful that no guide can be completely comprehensive. To keep the length of the guide manageable we've had to leave out many details, some of which might have seemed very important to some of you.

Although we are supportive of efforts to improve hospital-community collaboration, we are mindful that some readers may have had negative experiences, and that collaboration is not a panacea appropriate in all occasions. Thus, we offer a more nuanced understanding of the strengths and potential limitations/pitfalls of hospital-community collaboration, drawing upon recent research as well as the expertise of academics and individuals with extensive, hands-on experience as 'champions' of HCC. We do *not* offer a step-by-step plan or guaranteed recipe for success. In community work, strategies that have been successful in one situation can rarely be applied without modification in another. Complexity science teaches us that solutions that work for simple or complicated problems are much less helpful in

addressing problems that are inherently complex. For example, recipes and rigid protocols work well when it comes to baking a cake or sending a rocket to the moon, but they do not guarantee success in raising a child (see Figure 1 below). In complex systems of social interaction (most real world social interventions), ongoing responsiveness to *context* is very important: each combination of circumstances and people affects the development and effectiveness of HCC. A flexible and responsive approach to practice is therefore required. With this in mind, many parts of this guide are intended to encourage critical reflection and dialogue, through which you can examine and respond to the specific circumstances in your organization and community.

Table 1: Simple, Complicated & Complex Problems

SIMPLE: Baking a cake	COMPLICATED: Sending a rocket to the moon	COMPLEX: Raising a child
Recipe essential	Protocols needed	Rigid protocols often not very helpful
Easily replicated (follow directions)	Success with one increases likelihood of success with next	Success with one no guarantee of success with next
No expertise required	Considerable expertise required	Expertise helps, but responsiveness is key
Good recipe a good guarantee	Key elements required to succeed	Every child is unique; much uncertainty

Source: Adapted from Westley, Zimmerman & Patton (2006), *Getting to Maybe*. Random House Canada.

The remainder of this document is divided into two main sections. Section II, *Understanding Hospital Community Collaboration*, looks at what HCC is and why collaborations are formed. It also introduces some considerations regarding community development work. Section III, *Taking Action*, provides practical ideas and advice for those planning or involved in hospital-community collaboration. Many of the sections include critical thinking questions and advice derived from practitioners' experiences in the field. A glossary and additional references to supplement the topics covered in the guide are included in the Appendices. Resources permitting, a website is also planned, which will make available additional resource materials.

Our desire is to refine this guide based on feedback from those who could be or are using it as a resource. Your comments and suggestions are welcome and may be directed to: Dr. Blake Poland, blake.poland@utoronto.ca, 416-978-7542.

1.3 A Note about the Research

Much of the material in this guide draws from the findings of a federally funded research study: *Hospital Involvement in Community Action* (HICA). With funding from the Social Science and Humanities Research Council of Canada, from 2000-2005, the *HICA study* sought to understand how hospitals and community organizations in Ontario work together on initiatives that address community health issues. The study emphasized hospital-community collaborations that address determinants of health beyond the hospital walls. Detailed case studies (in 4 Ontario sites: urban, suburban, rural and northern) and a telephone survey (of community organizations in the Greater Toronto Area) were used to learn about the range of collaborations and working relationships that exist between hospitals and community agencies in Ontario, and the factors that influenced (enabled and/or hindered) the processes of hospital-community collaboration, within the policy, organizational and community contexts.

A summary of the study's findings is included in Appendix B.

With funding from the Change Foundation/Healthcare, Technology and Place Funding Alliance, we undertook a supplementary review of the literature and a distillation of the research findings, according to knowledge translation principles, to develop a Resource Guide on Hospital-Community Collaboration that could be useful to both hospital staff and community organizations, and that would be more accessible and practice-oriented than is normally the case with academic publications in scholarly peer-reviewed journals. As with the original HICA study, an advisory group of hospital-based and community-based practitioners, and decision-makers was convened to help shape the terms of reference of the *Hospital-Community Collaboration Knowledge Translation Project*. In addition, workshops were conducted (as part of other conferences and as stand-alone events) with each of these stakeholder groups to determine what materials and format would be most useful and relevant for practitioners and decision-makers. An early draft was sent to a wide cross-section of people from hospitals and community organizations in Ontario as well as several policy-makers and their comments gathered through a follow-up telephone interview. The result of these synthesis and consultative activities is the Resource Guide you have in your hands.

For more information about our research, please see the following publications.

Poland, B., Boutilier, M., Tobin, S., & Badgley, R. (2000). The policy context for community development practice in Public Health: a Canadian case study. *Journal of Public Health Policy*, 21(1), 5-19.

Poland, B. D., Fell, L., Graham, H., Lum, J., Walsh, E., Williams, P. et al. (2001). 'We're hired by the hospital, but we work for the community': Examining hospital involvement in community action. *Hospital Quarterly*, Spring), 52-59.

Poland, B. D., Graham, H., Walsh, E., Williams, P., Lum, J., Polzer, J. et al. (2005). 'Working at the margins' or 'leading from behind'? A Canadian study of hospital-community collaboration. *Health and Social Care in the Community*, 13(2), 125-135.

II. Understanding Hospital-Community Collaboration

To participate effectively in hospital-community collaboration, it is helpful to have an understanding of what these collaborations can look like and how they work. The terms ‘collaboration’ and ‘community’ mean different things to different people. So, we begin by defining what we mean by these terms for the purposes of this guide. We briefly discuss some of the reasons for collaboration and give some real-life examples. Next, we consider the role of the health sector in addressing determinants of health (the social and economic conditions that influence the health of individuals and populations - see Appendix C), as well as some of the important cultural differences that may exist between hospitals and community groups. This section concludes with an overview of community development as an approach to establishing effective and equitable working relationships among partners.

2.1 What is Community?

There are many ways to define ‘community’. The term is often used to refer to a geographic area (e.g., a neighbourhood) or to communities of identity (e.g., ‘the gay community’ or the ‘Chinese community’). Community may also be used to describe certain demographic groups (e.g., youth, seniors or new immigrants), interest and advocacy groups (e.g., psychiatric consumer/survivors) or organizations (e.g., the non-profit community, the business community).

Some examples of community groups and organizations include:

- Health care and social service providers (e.g., Community Health Centres, Community Care Access Centres, long-term care facilities, clinics or private physicians, public health, and other government departments);
- Community-based non-profit organizations and groups (e.g., patient support groups, community support services, churches and other faith-based organizations, issue advocacy groups or coalitions, residents or ratepayers associations, trade unions);
- Schools and post-secondary institutions;
- Private sector organizations or associations.

“The experience of community is less about the physical space in which people interact than the pattern and nature of relationships that exist between people.” (Lyon, 1989)

Because collaborative work usually takes place between people located in organizations, this several sections of this guide emphasizes the ways in which organizational values, policies and practices can support or hinder collaborative work (e.g., sections 2.5, 3.1 and 3.4). This should not take away from the important role of individual ‘champions’ and practitioners in making things happen in their communities (as discussed in section 3.2).

2.2 What is Hospital?

Ontario has four different hospital types including Public Hospitals, Private Hospitals, Federal Hospitals, and Cancer Care Ontario Hospitals.

Provincial and territorial governments are responsible for the provision of hospital care in their jurisdictions. This includes planning, financing, and evaluation.¹

¹ Health Services in your community. http://www.health.gov.on.ca/english/public/contact/hosp/hospfaq_dt.html

Insured hospital services are defined under the *Canada Health Act*. They include medically necessary in-patient and out-patient services such as:

- Standard or public ward accommodation;
- Nursing services;
- Diagnostic procedures such as blood tests and X-rays;
- Drugs administered in hospital; and
- Use of operating rooms, case rooms and anaesthetic facilities².

In Ontario, there are 227 hospital sites. Of that, 150 are hospital corporations (e.g. Hamilton Health Sciences), and an additional 77 facilities are hospitals under an umbrella corporation (e.g. Hamilton Health Sciences' Henderson site).

Ontario has seven private hospitals currently providing services under the *Private Hospitals Act*, six of which receive funding for their operations from the Ministry

Hospitals are further divided into following categories: general, specialized, and teaching hospitals.³

- The most widely recognised hospital type is the general hospital, which is set up to deal with disease and injury. Modern community hospitals. A general or community hospital is most often the major health care facility in the region.
- A teaching hospital (or university hospital) combines patient health care with teaching medical students. Research is an integral and crucial function of teaching Hospitals in Canada. It combines speciality in research with patient care, training health care professionals, and furthering health care knowledge.⁴
- Specialized hospitals deal with specific medical needs such as children care, geriatric care and so on.
- The Provincial Psychiatric Hospitals are designated psychiatric facilities under the **Mental Health Act**, and comply with that **Act** when providing specialized mental health services. However, many Public hospitals are also designated psychiatric facilities under the **Mental Health Act**, and provide a range of in-patient and out-patient mental health services, in addition to the medical, surgical and other services provided at general hospitals.
- Palliative Care Hospitals, such as (Princess Margaret Hospital- Toronto) have a team of palliative care doctors, nurses and social workers that provide care for terminal illnesses. Care includes: pain management, symptom management, social, psychological, emotional and spiritual support and Caregiver support⁵.
- long-term care facilities provide care and services for people who no longer are able to live independently or who require 24-hour supervision or personal support.

² Hospital Care, (2004). Health Canada.
http://www.hc-sc.gc.ca/hcs-sss/hospital/index_e.html

³ http://en.wikipedia.org/wiki/Teaching_hospital

⁴ “[The Indirect Costs of Health Research in Canada’s Teaching Hospitals](#),” October, 2000. Association of Canadian Academic Healthcare Organisations.

⁵Canadian Hospice Palliative Care Association. http://www.chpca.net/menu_items/faqs.htm#faq_dif

- Complex continuing care is a higher level of care than what is provided by long-term care centres and other nursing facilities.⁶ In Ontario, the term “complex continuing care” (CCC) is used interchangeably with “chronic care”. Complex continuing care facilities provide continuing, medically complex and specialized services to all ages, sometimes over long periods of time. CCC is provided in hospitals for people who have long-term illnesses or disabilities typically requiring skilled, technology-based care not available at home or in long-term care facilities. CCC provides patients with room, board and other basic necessities in addition to medical care.

2.3 What is Collaboration?

Collaboration comes in various shapes, sizes, and durations. There are many possible ways that organizations can work together (THCU 2001, Winer & Ray, 1994):

- *Network*: to share information and expertise.
- *Consultation/Advisory*: to receive input regarding proposed changes, or to gather ideas for future activities.
- *Cooperation*: work-sharing arrangement, often informal, where individual organizations retain authority and act independently.
- *Coordination*: activities are planned with some discussion among partners to address gaps and avoid duplication of service; resources are acknowledged and can be made available to others.
- *Coalition*: formed to increase the power and influence of its members through collective action for the purposes of advocating for social change.
- *Formal collaboration*: formed to share resources, risks and decision-making; usually longer-term and involve a higher intensity of activities

These kinds of working relationships differ in the extent to which power and decision-making is shared among partners. For example, hospitals often ‘consult’ with community representatives or work with local service providers to coordinate services. These arrangements are typically initiated by the hospital and the hospital maintains control over the agenda and process. By contrast, work that is truly collaborative involves an equitable working relationship between the hospital and community group(s); decision-making authority is shared with community groups and attention is paid to capacity building⁷ and community participation in agenda-setting, problem definition, identification of solutions, implementation, and evaluation (see section 3 for more about using a community development approach to collaboration).

Collaborations also differ in terms of how formal their structures and processes are. Formal collaborations usually involve a written partnership agreement, terms of reference, and well-defined roles and responsibilities for participants. On the other hand, many collaborative relationships involve only a few people who are working together across their organizations to get something done (e.g., meet a clients need, extend a particular service). These informal collaborations may not outlive their specific objectives or they may form the foundation for an ongoing working relationship or a more formal partnership.

Keep in mind that groups may start working together informally and then decide, at some point, that they need to introduce more formal structures and processes. Also, established partnerships may disband if their mandate is no longer relevant or because members lose interest. The important thing to recognize is

⁶ <http://www.torontorehab.com/patient/ccc/ccc-pfaq.htm>

⁷ Building community capacity may involve providing training and support in areas such as: shared power, sustainability, leveraging resources, health education, promotion and communication (TCHU, 2001).

that collaborations can and should be adaptable, and the objectives of the participants should dictate the structure (and not the other way around).

2.4 What is Hospital-Community Collaboration?

Drawing on extensive field research, as well as the relevant published literature, we define hospital-community collaboration as: *multiparty problem solving... undertaken jointly by hospital staff and members of community organizations... utilizing a range of participation processes, from consultative to more community development approaches... ranging in degree of formalization, from formal partnerships to informal working relationships... and focussing on a wide spectrum of issues, from clinical care to the broader determinants of community health*

HCC may be initiated by hospital or community-based players. We see it as ideally possessing some (preferably all) of the following qualities:

- Shared authority and responsibility (for both the process and the outcomes of the collaboration);
- Joint investment of resources (financial or in-kind);
- Shared liability or risk-taking (and credit for successes);
- Mutual benefits;
- Shared information & decision-making.

2.5 Why Collaborate?

Creating healthier communities and overcoming complex problems often requires collaborative solutions that bring communities and institutions together to build upon the assets, strengths and capacities of each (CCPH, 2006). Often, collaborations are formed to respond to an issue or need that cannot be adequately addressed by one organization on its own.

Many healthcare providers recognize the importance of working with community partners to improve the quality of patient care (before, during and after a hospital stay), and to undertake health promotion activities intended to prevent illness and improve the overall health of the community. Many community groups regard hospitals as important community assets and expect them to be involved in multi-sectoral initiatives to address local issues. Working together across organizations and sectors allows for greater coordination of efforts among the diverse groups and organizations working on many fronts to address community health issues.

The following are some of the more common reasons for hospitals and communities to work together (see Table 1 for examples of joint initiatives undertaken by hospitals and community groups).

- To improve the quality of patient care;
- To coordinate services with other healthcare and social service providers;
- To respond more effectively to the health care needs of diverse populations;
- To improve communication and information sharing among organizations;
- To increase staff skills and knowledge;
- To expand health education for patients, their families, and other community members;
- To deliver services more efficiently by leveraging the assets and capacities of the partners;

- To collectively address the determinants of health in the community that impact the health of the local population (in this guide, we emphasize this area of focus).

Table 2 - Examples of Hospital-Community Collaboration

Project	Purpose	Partners
Aboriginal Health Initiative	<ul style="list-style-type: none"> • Improve access to health services, support diversity, and help local health providers offer culturally relevant services to the Aboriginal community. 	<ul style="list-style-type: none"> • Representatives of local Band Councils • Aboriginal community members, • Community health centres • Local and regional hospitals
Community Wellness Committee	<ul style="list-style-type: none"> • Identifying opportunities for the development, implementation and evaluation of health promotion and illness prevention projects 	<ul style="list-style-type: none"> • Hospital board and staff members • Hospital volunteers • Local community residents • Public health unit
Ending Violence Coalition	<ul style="list-style-type: none"> • Raising awareness of violence against women in local immigrant populations. 	<ul style="list-style-type: none"> • Staff members from local hospitals and community health centres • City police • City councilors • Representatives from legal clinics
Road Safety Coalition	<ul style="list-style-type: none"> • Reducing injuries and deaths related to road accidents. 	<ul style="list-style-type: none"> • Local Service Club representatives • Municipal and provincial police • Manager of a local truck driving school • Interested citizens • Volunteer organizations • Local ambulance organizations • Local hospital(s)
Joint Discharge Program	<ul style="list-style-type: none"> • Planning the discharge of patients into the community. • Coordinate services 	<ul style="list-style-type: none"> • CCAC Case Managers • Hospital discharge planner and other staff • Community support services
Rehabilitation Resource Centre	<ul style="list-style-type: none"> • Providing consumer information, peer support, community education for individuals recovering from brain and/or physical injuries/illnesses 	<ul style="list-style-type: none"> • Hospital rehabilitation clinicians • Canadian Paraplegic Association • Local public library • Representatives from various self-help organizations
Rural Wellness Committees	<ul style="list-style-type: none"> • Facilitating access to services and information on the determinants of health for rural women and elderly rural residents. 	<ul style="list-style-type: none"> • Hospital staff • Public health unit, • CCAC Case Managers • Victorian Order of Nurses • Faculty from the school of Rural Planning from two universities • Rural residents • Local farm safety association chapter

Health system incentives for hospital-community collaboration

In Ontario, there has historically been limited political interest in encouraging hospitals to broaden their scope and role to include collaborative initiatives, and there have been few, if any, financial incentives for hospitals to collaborate with community groups. The sustainability of HCC has, at times, been threatened by government policy shifts, the erosion of provincial funding for community services, hospital restructuring, and the amalgamation of municipalities. Hospitals in other Canadian provinces have faced similar challenges (although, their services are organized differently).

The implementation of *Local Health Integrated Networks* (LHINs) in Ontario is expected to lead to increased support for community involvement and collaboration among local service providers, as well as greater integration of services. LHINs are non-profit organizations that will gradually assume responsibility for planning, coordinating, integrating, managing, and funding health care for defined geographic areas. At the time of publication of this guide, there are fourteen LHINs in Ontario.

Part of the LHIN mandate is to engage local communities in health system planning and priority-setting through:

- Developing mechanisms and channels for community dialogue and engagement (e.g., formal channels for citizen input and community consultations), and
- Responding directly to unique local concerns and requirements.

To learn more: The provincial LHIN website is <http://www.lhins.on.ca>. The CCHSA site is <http://www.cchsa.ca>.

Hospitals and other healthcare organizations may also emphasize community collaboration in order to meet *accreditation* standards. Accreditation involves an arms length, peer-review evaluation of the quality of their services, measured against a recognized and validated set of national standards:

- The Council on Health Services Accreditation (CCHSA) requires service delivery teams to regularly assess the overall service needs of the populations they serve.
- The Achieving Improved Measurement (AIM) Program of the CCHSA requires organizations to work with the community and other organizations to regularly evaluate the community's health status, its capacities (strengths and assets) and health needs.
- **Community Organizational Health Inc.**, or COHI, owns and administers the quality improvement and accreditation program called [Building Healthier Organizations](#) (BHO). Developed in 1998, COHI is a federally incorporated not-for-profit organization. Fifty-five organizations are currently members of COHI, including fifty-four community health centres.

Organizations use the structure of the BHO Standards to help enhance their planning processes and systems within their organization. These cross-organizational systems allow coordination across various programs, satellites and other off-site program locations, and through program expansions and amalgamations.

Achieving accreditation can be a significant point of pride within the organization and a morale booster for staff, volunteers and Board, as it provides credible external feedback about the organization's accomplishments

What do hospitals have to offer?

Some community organizations may not have considered collaborating with local hospitals, particularly when it comes to health promotion and addressing determinants of health. Or, they may be hesitant to do so because of prior negative experience, or because of perceptions they have about hospital culture. Nevertheless, many community agencies participating in the HICA research study indicated that they had initiated working relationships with a local hospital. They also reported being reasonably satisfied with these working relationships.

Our research indicated that many hospitals are receptive to working with various community stakeholders and, in many cases, they are getting better at doing it. Hospitals are clearly an important community asset that, under the right circumstances, can contribute a great deal towards collaborative initiatives in terms of:

- Financial resources;
- Staff and volunteer time;
- Specialized expertise;
- Education and training;
- Meeting space; and
- Access to clients.

“Hospital processes need to be amenable to the ways in which community organizations function and should take care not to judge community organizations or their representatives if they do not do their work within a bureaucratic and formal committee structure...there ought to be freedom to do things differently.”
(Former Hospital Board Chairperson)

Community organizations and groups stand to benefit as a result of participating in a working relationship with a hospital. Some of these benefits include:

- Better services for the populations they serve (access to care, quality of care, client satisfaction);
- Access to potential clients;
- Better awareness of their agency and its services among hospital staff;
- Better relationship with the hospital

Collaboration between community entities and hospitals can be a ‘two way street’ when both parties stand to benefit from what the other has to offer. Community groups often engage in collaborative work in order to start a dialogue and to maintain a ‘foot in the door’ in the decision-making process of larger, more powerful organizations, such as hospitals. Partners from those larger organizations frequently take on a ‘gatekeeper’ role: expressing support for the partnership agenda, but often limiting their support to actions that fit within their organization’s policy mandate (Stern & Green, 2005). Hospital staff involved in this work may experience tensions associated with a dual accountability towards both the community and their employer (Poland et al., 2001).

Of course, community organizations have a lot to offer hospitals also, including local connections, skilled and knowledgeable staff, understanding of local needs, capacities and priorities, specialized and complementary services, volunteers, etc.

“some of the consumer groups are terrified of the hospital taking over their group and branding it with the hospital philosophy, logo...because they are small, they’re fragile and they are fiercely independent, and they want to be autonomous.”
(Hospital Manager)

Addressing broad determinants of health: A role for the healthcare sector

“We've learned a lot in the past several decades about what determines health and where we should be concentrating our efforts. Much of the research is telling us that we need to look at the big picture of health to examine factors both inside and outside the health care system that affect our health. At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behavior. These factors are referred to as 'determinants of health'. They do not exist in isolation from each other. It is the combined influence of the determinants of health that determines health status.” (Health Canada, 2003)

On many occasions, there have been calls for the health sector to do more to proactively address determinants of health. Inter-sectoral efforts that reach across jurisdictional ‘silos’ are needed to effectively address these broader community health issues (e.g., coalitions for the prevention of low birth weights; advocacy around the provision of housing, school breakfast programs, domestic violence prevention).

Hospitals are prominent, publicly funded institutions with a mandate to improve the health of residents in their communities. It is common for hospitals to work with community partners to develop and run programs to address individual health-related behaviour (diet, exercise, smoking, substance abuse), or encourage participation in preventative health services such as breast cancer screening (Taylor et al 1996). But hospitals are, historically, less likely to get involved in efforts to deal with wider social, economic and environmental issues (e.g., homelessness, income inequality, food security, and air pollution) even though their staff often see the health consequences of these issues among their patients.

Some hospitals (or hospital-based practitioners) are doing this anyway, in the absence of a strong mandate from the province to do so. In some of these initiatives, health-care providers are playing a leadership role. In other cases they have more of a supportive role. The health promotion continuum shown on the next page illustrates the different degrees to which healthcare providers may engage in health promotion and community action.

Examples of efforts within the healthcare sector to incorporate health promotion and social determinants of health into their work include health-promoting hospitals and Community Health Centres. Both emphasize broad determinants of health and the importance of working collaboratively across sectors. On page 12, you will find brief descriptions of these organizations. Appendix C includes a fact sheet on the social determinants of health and their relevance to healthcare restructuring in Ontario (developed by the Greater Toronto Area LHIN working group).

“The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together...” (Ottawa Charter for Health Promotion, 1986)

Table 3: Critical Thinking Questions: *Where is your Organization on this Continuum?*

<p>Full commitment to health promotion, community development and community capacity building</p>	<ul style="list-style-type: none"> • Demonstrating strong commitment to a health promotion, community development, community capacity building, recognizing that the organization (hospital, CHC) has a responsibility to promote community health, and support action on broad the determinants of health. • Recognizing and addressing access and equity issues (barriers to access to care for marginalized groups - the homeless, those of diverse ethno-racial backgrounds, etc.).
<p>Moderate commitment to health promotion, community development and community capacity building</p>	<ul style="list-style-type: none"> • Working with non-marginalized groups such as churches and social service agencies on health and social issues, (e.g., teen suicide prevention in high schools). • Committing modest resources to supporting and working with community groups to address needs that are relevant to the organization's mandate (e.g., caregivers' network; self-help groups, public education, fundraising to assist community charitable causes). • Working with other agencies to develop joint educational disease prevention programming, or to coordinate services
<p>Health promotion and community action are not part of organization's mandate</p>	<ul style="list-style-type: none"> • Disease prevention education (delivered by staff to non-patients (patients' families & other local residents) in community settings • Patient education programs • Everyone's time and energy is consumed with curative or palliative health care. Health promotion and community action not seen as necessary or realistic component of organization mandate.

Health Promoting Hospitals

A health promoting hospital does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the aims of health promotion, develops a health promoting organizational structure and culture, including active, participatory roles for patients and all members of staff, develops itself into a health promoting physical environment and actively cooperates with its community (based on the *Budapest Declaration on Health Promoting Hospitals*. WHO, Regional Office for Europe, Copenhagen, 1991).

The vision of health promoting hospitals includes these dimensions:

- good quality treatment and care in a healthy health care setting; extending treatment of actual diseases towards disease prevention and promotion of positive health; strengthening patient orientation towards empowering patients to take control over the factors that influence their health
- healthy workplaces for staff
- strong partners for public health in the communities
- healthy and sustainable organizations (source: WHO Collaborating Centre for Health Promotion in Hospitals and Health Care).

For more information about Health Promoting Hospitals, visit <http://www.hph-hc.cc>.

Community Health Centres and the Determinants of Health

Community Health Centres (CHCs) are non-profit, community-governed organizations that provide primary health care, health promotion and community development services, often in collaboration with hospitals or other community service providers. In Ontario, there are more than 50 CHCs.

The philosophy behind the CHC model includes a broad definition of health and consideration of the social determinants of health. The Association of Ontario Health Centres explains:

“We believe that effective primary health care addresses the social determinants of health, including social inclusion, access to shelter, education, income and employment security, food and stable eco-systems. It encompasses primary care, illness prevention and health promotion, and uses a community development approach to building healthy public policy in supportive environments.

...we are a key source of community infrastructure through which to deliver a range of integrated community-based services and to respond to health-related community concerns. Our member centres are specialists in delivering primary health care that is integrated with other social and health services partners.” (source: www.aohc.org)

Advice from the Field:

Possible challenges and pitfalls to be aware of...

While there are many compelling reasons to consider hospital-community collaboration, it is not appropriate for every situation and needs to be approached with caution in order to avoid some common pitfalls. Potential difficulties that you may encounter include the following:

- Expecting too much too soon, especially during the start-up phase. You can't always expect immediate results because successful working relationships, based on trust and mutual understanding, take time and effort to develop.
- Be careful that you don't rush into formalizing your working relationship prematurely. A more informal or ad hoc working relationship may be more appropriate in some instances.
- The burden of the collaboration's work falls on the shoulders of one or a few individuals.
- Competition for funding between/among community organizations and hospitals can create "turf battles" that may threaten collaborative relationships.
- In the context of being expected to do 'more with less', funders may see collaboration as a substitute for new funding when, in fact, more resources are needed to achieve the intended results.
- Community energies may be co-opted to serve other institutional agendas such as improved public relations, shortened lengths of stay in hospital beds, or the downloading of services to the voluntary sector.
- The needs of the hospital may take precedence over those of community partners.
- Collaborations may be seen as a 'luxury' or 'frill.' If community collaboration is not part of the organization's core mandate, it may be the first to thing to be cut when budgets are tightened.

2.6 Understanding Hospital and Community Cultures

Collaborative work brings together organizational cultures that often differ significantly in terms of core values, usual ways of working, and perspective on health and its determinants. Typically, medical care is provided within the walls of the hospital or clinic and operates according to an individualistic, biomedical view of health. In contrast, health is seen as a process and as a resource for living in health promotion/ community development. Community workers try to focus their actions and interventions on the broader social conditions that affect community health.

It is important not to underestimate the effort that may be required on the part of hospitals and community organizations to get to the point where each party understands and appreciates the other's perspectives, values, and ways of doing things. Our research suggests that hospitals may find it difficult to accommodate the more flexible and organic nature of collaboration and community development because they are used to tight timelines and accountability structures, 'top-down' reporting and decision-making processes.

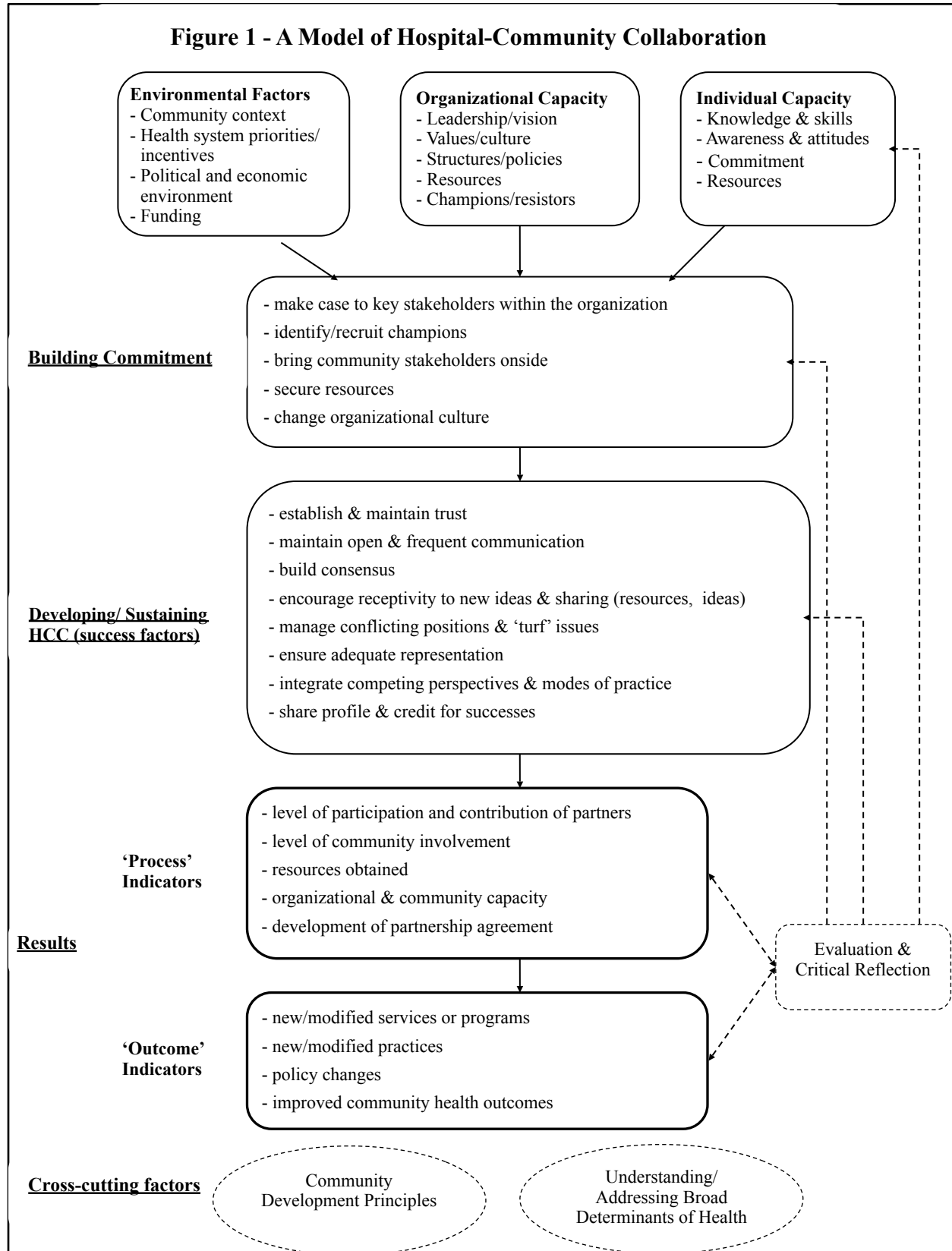
Table 2 (below) is perhaps a bit of an over-simplification, but it illustrates the 'cultural divide' that can exist between many hospitals and community organizations.

Table 4 – Contrasting Organizational Perspectives and Modes of Practice*

Perspective/ Mode of Practice	Hospital (<i>biomedical perspective</i>)	Community Organization (<i>community development perspective</i>)
Focus	Disease management, acute care	Serving the needs of individuals holistically, addressing broad determinants of health
Unit of Intervention	Individuals, patients	Community members (particularly members of marginalized and/or underserved groups)
Planning and Decision-making	Top-down, bureaucratic, hierarchical	Collaborative, consensus-based
Basis of Authority	Medical expertise	Experiential knowledge
Authority Figures	Physicians, Hospital Administrators	Community leaders/members
Indicators of Success	Morbidity and mortality, hospital utilization rates, funding	Community participation, skills development, new funding/resources
Locus of Health Work	Hospital (within the four walls)	Community (beyond hospital walls)
View of Health Determinants	Individual lifestyle factors	Social conditions
Emphasis	Outcomes	Process and outcomes

- As always, there is a risk in stereotyping agencies in these terms. We do not wish to give offence to those from either hospitals or community organizations that do not fit the mold. There are always exceptions. An alternative labeling of the two columns could be “large clinically-oriented organizations” and “smaller community-oriented organizations”, in recognition that some large non-hospital institutional players may look more like the former than the latter, and some smaller hospitals might look more like the latter than the former.

Figure 1 - A Model of Hospital-Community Collaboration



III. Taking Action

After reading Part II, you will hopefully have a clearer understanding of the nature of hospital-community collaboration. In this chapter, we discuss approaches to effective collaborative work. First, we describe community development and the role of organizations in supporting community development work. Also, the role of ‘champions’ in HCC is highlighted. Some questions are provided to help organizations assess their readiness to take part in collaborative work. We close this section with suggestions for developing, evaluating, and sustaining effective collaborations.

As you review these sections, you may find it helpful to refer to the model of hospital-community collaboration shown in Figure 3 on the previous page. This model provides a visual snapshot” of the HCC ‘process’.

3.1 Using a Community Development Approach

Community development is a key health promotion strategy. It is about working with people to develop their capacity to achieve greater control over the determinants of their health by identifying and building individual and community assets and skills and by working to remove individual, interpersonal, organizational and structural barriers to improving community health. Community development is not a specific activity or program, but a way of thinking and acting based on certain core values and beliefs such as mutual respect and empowerment.

Those collaborations that consciously take a community development approach involve the sharing of decision-making with community partners. They also pay attention to increasing the capacity and self-sufficiency of those partners. Health care and social service develop new and expanded partnerships of individuals, families and communities, and to enable them to identify and meet their own health needs. When power and decision-making is shared, hospital-community collaboration has the potential to empower community.

A community development perspective recognizes that:

- Community members have significant assets and skills, not just problems;
- The hospital needs the community just as the community needs the hospital;
- Organizations need to be flexible and open to addressing issues identified by the community; and
- Healthcare workers need to be sensitive to their own privilege and ways of operating that might reinforce power imbalances between their organization and community members (Poland et al., 2001).

“It is important that practitioners reflect on the extent to which their work is focused on problems that have been identified by the community...Service providers may decide that the biggest issue in a community is coronary heart disease, while the community itself may be more concerned with the high levels of crime in the area. Negotiating these different perspectives [is] important in planning effective action.” (Nutbeam & Harris, 2004, p.34).

In practice, promoting community health requires a commitment to active community participation in all stages of collaboration (not just when it’s institutionally convenient), including agenda-setting, problem definition, identifying solutions, implementation, and evaluation.

What community development is not

Community development is sometimes confused with the following:

- Programming that is based in a community setting, but is controlled by the hospital or other institution (e.g., public health unit);
- Consulting with community stakeholders (typically, there is a lack of clarity about how input from the community consultations will be used to set priorities or make decisions);
- Needs assessment (along with consultation, this may be a step in the process of CD, but alone they do not constitute CD practice);
- Educational or outreach initiatives.

Organizations often consult with or ‘engage’ community members and stakeholders as part of a needs assessment, pilot project, or program evaluation. It is important to ensure that such engagement processes are part of a genuine community development approach rather than exercises to give the impression that community members were involved. Table 3 shows how the ‘promise’ of community engagement is not always realized in practice. You may wish to use this as a tool to help you assess how legitimate a community engagement process really is.

Community development involves:

“Helping people to develop the skills they need, and removing the structural barriers that prevent them from achieving their full potential as members of the community” (Hoffman & Dupont 1992)

Empowerment is: *“A social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing social and political environments to improve equity and quality of life”*
(Minkler & Wallerstein, 2002)

Table 5: Community Engagement: Assumptions and Reality

Common Assumptions (the promise)	Common Obstacles (the reality?)
<p>All parties genuinely interested in community input:</p> <ul style="list-style-type: none"> • believe community knows best • willing to abide by community input even when it doesn't match own views 	<p>Community could be overly cynical or overly optimistic, or anywhere in between.</p> <p>Those with decision-making authority want to appear to be consulting the community, but reserve the right to do as they see fit (e.g., take community input 'under advisement'):</p> <ul style="list-style-type: none"> • Not completely convinced community (always or 'in this case') knows best • Reluctant to hand over control to the community
<p>Those who participate have important knowledge that is not available through other means</p>	<p>Some of the most informed will not be consulted or heard (e.g., frontline staff)</p>
<p>Everyone comes to the table as equals</p>	<p>Powerful stakeholders influence the process, to resist change, and to ensure their interests are met</p>
<p>Specific methods for capturing feedback and inserting it at the right points and times into decision making processes exist and are used</p>	<p>Much information will be lost in the process of translation:</p> <ul style="list-style-type: none"> • How feedback is solicited and summarized • How it is made available for decision-making
<p>Community input is heard and understood</p>	<p>Misinterpretation and 'selective hearing' arise from differences in world view, values, beliefs and assumptions</p>
<p>Community input is widely cited and used in decision making</p>	<p>Community input is selectively highlighted when it fits with what powerful stakeholders believe and value, otherwise it is resisted, rejected, reinterpreted or ignored</p>

3.2 How Organizations can Support Community Development Work

Hospital staff who participated in our research described the need to work on two fronts at the same time:

1. Building trust and collaborations 'on the ground' in the community; and
2. Building the profile and legitimacy of community work within their hospital.

Creating an organizational culture that supports community development work is an ongoing process that requires careful planning and strong leadership. The organization must (re)examine its role and responsibilities in the community, and how these are reflected in broad policies and procedures as well as in day-to-day practice. The values and principles associated with community development can potentially filter through all parts of the organization, including programs and services, communications, community

relations, human resources, governance and policy. The process is really about developing the *capacity* to work more effectively with community partners.

Some ways that organizations can support community development work include the following:

1. *Be flexible*

- A flexible approach to community work is essential because the process and outcomes of your efforts are likely to change over time as you and your partners clarify values, priorities and capacities.

Successful collaborative work requires the organization to “*act with integrity in working collaboratively... as well as through modeling community development principles and processes internally with staff. All of this requires an orientation towards critical reflection, learning, innovation and risk-taking.*” (Germann & Wilson, 2004)

2. *Foster Collaborative Work*

Organizations can nurture capacity for community development in several ways:

- Willingness and ability to build bridges among organizations, individuals, and the community to promote health;
- Respect for your own abilities *and* those of your partners;
- The ability to accept ambiguity, risk, compromise, trust and sharing.

3. *Design jobs appropriately*

Creating organizational capacity for community development may require a change in how jobs are designed. Some important factors to consider include:

- Clearly defined roles, responsibilities and priorities;
- Flexible work hours (to be able to accommodate meetings and events which may occur outside of normal operating hours);
- Manageable workloads (to allow sufficient time for staff to do community work without it competing with their other responsibilities).

4. *Provide adequate funding and time*

- Adequate funding is essential in order to provide ‘space’ within the organization to build capacity for community development;
- Acknowledge that community development work is often difficult and time-consuming – the building of trusting relationships does not happen overnight.

“*I think you can really learn from your mistakes...[staff] weren’t going to be torn apart in front of their colleagues if they made a mistake. We really looked at how you build trust. And that was internally, but it was also externally...what you do to build trust both within the organization and with your other partners. And a lot of that comes down to just... good communication and respectful treatment*” (former hospital CEO)

5. *Collect and Use Appropriate Information*

- Collect reliable data on health status and determinants of health;
- Identify and invite feedback, both formal and informal, from leaders in the community.

- Consider using an asset-mapping approach to develop an appreciation of the community’s strengths, challenges and needs

To learn more: about “asset based community development” refer to *Asset-Based Community Development Institute* (ABCD) website <http://www.northwestern.edu/ipr/abcd.html>.

6. *Develop staff knowledge and skills*

- Some of the skills crucial to community development work include: environmental assessment, group facilitation, participatory planning, political advocacy, oral and written communications, cultural and religious sensitivity, critical thinking, research and evaluation. Rarely will any one individual possess all of these skills. But it may be possible to encompass a diverse range of skills within work teams or organizations.

7. *Leaders Demonstrate Community Development Principles*

- Leaders who model community development principles in their work strive to create a supportive work environment by helping staff at all levels to develop and refine their skills, encouraging them to take risks and giving them opportunities to have a say in the decisions that affect their work. In doing so, they enhance their organization’s capacity to collaborate with community partners.

“Someone at the management level needs to...cheerlead collaborative projects...and use their budgets to allocate monies for community projects or frontline staff positions.”
(former hospital CEO)

8. *Evaluate*

- Collaborative work often has multiple goals, some of which are difficult to track and measure (e.g., building trust or capacity). Therefore, conventional approaches to evaluation may not be appropriate for assessing this kind of work (see section 3.5 for further discussion about evaluating collaborations).
- Ensure the involvement of participants (and where applicable, consumers/clients who are affected by the work) in the evaluation process.
- Recognize that it can take a long time for a group to establish relationships and work towards concrete results.

Advice from the Field:

How hospitals can build trustful relationships with community groups

- Acknowledge the resource constraints under which community organizations function.
- Show commitment to building strong relationships with community partners, demonstrate respect and goodwill, and be willing to listen and learn about community ideas and concerns.
- Consider different ways in which you can share or transfer resources to facilitate collaboration (material or in-kind).
- Don’t be too quick to capitalize on what’s in it for the hospital (although this may be important in selling collaborative work internally).
- Share credit for collaborative successes.

3.3 The Role of Champions

As we have seen, organizational factors are important in hospital-community collaboration. But successful collaboration also depends upon the knowledge, skills, and commitment of individual participants. In our research, there was strong agreement among respondents that effective leaders and ‘champions’ are essential to initiating and maintaining hospital-community collaborations. The loss of a champion (through turnover, reassignment to other tasks, or burnout) is often a serious setback to the collaboration.

Champions translate the organization’s values into action by ‘walking the talk.’ They work to create spaces for HCC, by actively advocating for this work and providing support to frontline staff who are already involved in collaborations. In so doing, champions increase the organization’s capacity to collaborate successfully.

“Hospital leadership only works if the hospital isn’t leading. It can’t be seen as a hospital takeover... I think you have to lead from behind on these initiatives...to make them successful...you’ve got to build on the skills...of the community as well as...creating the final thing that they want. A transportation system...or a youth club. So they have to be sustaining. And you need to be able to help the community get there.” (Hospital Senior Manager)

Ideally, champions have the skills and decision-making latitude within an organization to:

- Navigate sometimes tricky internal political waters;
- Build legitimacy for HCC within the organization and among influential stakeholders (e.g., funders, politicians);
- Facilitate access to resources for frontline staff and the community;
- Support frontline staff (e.g., by providing flexible hours, delegating decision-making authority, guidance and mentorship).

Champions possess a number of important skills that support collaborative work:

- *Communication skills*: to generate interest in HCC and specific issues and to bring people together around common issues;
- *Facilitation skills*: to generate agreement among players, and to define project scope and shared goals;
- *Leadership skills*: to bring people together and to get projects off the ground;
- *Advocacy skills*: to promote understanding of HCC and/or community development within the hospital, community organization and community at large and to raise awareness of specific issues (e.g., domestic violence, homelessness);
- *Support skills*: to create an atmosphere of trust.

“[this project] wouldn’t have happened if it was a senior management initiative. Freeing up... some resources, that’s a small piece. The big piece is having the enthusiastic staff who were willing to go the extra distance to write the proposals and move the mountains and get the Advisory Committee going.” (Hospital Senior Manager)

Collaboration as ‘invisible’ work

Whereas collaboration may be central to the work of many smaller organizations, it may seem to only flourish at the ‘margins’ in larger organizations who frame their core mandate in clinical and biomedical terms. For champions employed in these large organizations it can be difficult to make space for hospital-community collaboration and to gain legitimacy and profile for community action initiatives. At other

times, having a high profile may invite unwelcome scrutiny and become a liability when budget cuts focus attention on work that some may see as a ‘luxury’ in comparison to core services such as direct patient care.

In our research, we found that collaborative work is heavily *gendered*. Collaboration was almost always championed and undertaken by women. While it can be argued that women are more likely to possess the skills and commitment required to establish strong interpersonal working relationships, it is often also true that the relational work that women do is often “rhetorically valued... but under-appreciated and devalued” in more (male-dominated and) clinically-oriented environments such as hospitals (Poland et al., 2005).

3.4 Is Your Organization Ready to Collaborate?

The preceding sections reinforce what you probably already know: successful collaboration relies on more than just good intentions. An important part of preparing for collaboration is assessing your organization’s environment, both internal and external. Below is a list of critical questions that can help your organization or group determine its readiness to support meaningful collaboration. We recommend that you set aside some time to review these questions with your colleagues.

...on establishing a common set of values

- What are your organization’s values/philosophical orientations?
- Are these values reflective of your community and/or local community agencies?
- Do they support collaboration? If so, how?

... on thinking broadly about the concept of health

- How does your organization understand health and the determinants of health?

... on community involvement

- How does your organization define the ‘community’ or ‘communities’ that it works with?
- How is your organization’s mandate and accountability to the community and community health understood internally?
- In what ways is the community involved in hospital planning and decision-making?
- Does your organization understand equitable participation in terms of the operational capacity of small community agencies?

...on operational capacity (staff and resources)

- Who are the leaders/champions in your organization? What are their values, background, and experience?
- Do you need to cultivate other leaders/champions? If so, what skills, positions, and experiences are important?
- How much autonomy do front-line staff members have to initiate, respond to, and advocate on behalf of issues identified by the community?
- What are the qualifications and performance expectations for staff facilitating HCC?
- Do responsible staff/leaders have the skills and/or experience to successfully facilitate collaborative work? What opportunities are there to provide professional development and training?
- Does the organization understand the need for an independent facilitator to deal with conflict resolution?
- How does (will) your hospital define and measure success with respect to hospital-community collaboration?

3.5 Developing Effective Collaborations

Collaborative work is a complex process, one that is both an art and a science. Effective collaboration requires an understanding of and attention to a wide range of factors, including communication methods, leadership, conflict resolution, and issues of power and ‘turf’ (to name but a few). There is an extensive literature in print and on-line that can assist you in developing effective inter-organization collaborations and partnerships. Rather than review this literature here, we encourage you to consult some of the sources listed in Appendix A. Below, some basic considerations for developing effective collaborations are described as a starting point.

Stages of developing a collaborative relationship

The development of collaborations and partnerships is often understood in terms of a series of stages or steps. Thinking about collaborations this way, particularly those of more formalized nature, can be helpful in planning your work and assessing progress. In practice, however, these stages will often overlap and partners may need to revisit earlier steps in order to ensure that their work remains relevant to participants and to the communities they serve. As a general guideline, Cauley (2000, p.13-15) identifies three stages of ‘partnership development’ and describes what you might expect at each one:

1. *The Identification Stage.* During this stage, the participants are getting to know each other and determining the scope of work of the potential partnership (or collaboration). Crucial questions to be asked include:
 - Who should be involved?
 - What do we say we want to do? Why is it important, particularly at this time?
 - What resources do we have to move forward, what additional resources do we need, and how can we obtain them?
 - How will we know we have been successful?
2. *The Development Stage.* The group continues to negotiate shared mission, values, goals, and expected outcomes. Often, previously agreed-upon issues need to be revisited, tensions may surface, the process of moving forward may stall, and members may reevaluate their participation. T
3. he participants must continue to ask themselves the questions from the previous stage and begin to put into commonly understood language the things upon which the group agrees. Participants also must identify: *‘what is really at stake for our constituencies?’*
3. *The Maintenance Stage.* The participants, now invested in the partnership, begin to develop expectations about how [it] will benefit their clients; also, they begin to see that compromise may be required to reach their shared goal. The partnership’s mission, values, goals, and expected outcomes may continue to be clarified. Questions and issues raised during the identification stage may need to be revisited regularly.

“If you don’t have clarification and agreement ... first, you’re bound to end up at a point where ... what you started out with isn’t anywhere what you wanted in the first place... [second] it’s very unfortunate because you want to maintain the uniqueness of the [community agency] ...and it’s approach” (CHC Executive Director)

Advice from the Field:

Suggestions for community organizations considering collaboration with a hospital

These suggestions are derived from interviews conducted during the *Hospital Involvement in Community Action* study.

Don't be Afraid to Approach the Hospital

- Take the initiative to explore the potential for working collaboratively.
- Approach this with a healthy degree of caution and take into account the power imbalances and cultural differences that may exist between organizations.

Find Allies within the Hospital

- Look for a champion within the hospital to work with you, someone who can provide an 'insider perspective' on how to get the hospital inside.
- Your first point of contact should be someone who will be receptive to your ideas and who might get excited about working on an issue of mutual interest. Ask about who has 'community' issues as part of their portfolio or responsibility (e.g. in some hospitals there is a department of community relations, community integration, or community health).

Assess the Hospital's Commitment to HCC

- Do some research in order to determine the hospital's motivations and commitment to doing collaborative work, and to assess the 'fit' between the culture and values of your group / organization and those of the hospital in question.

Make the Case

- Make a convincing case to hospital management and/or staff for working in collaboration. Why is the issue important? What are the benefits of collaborating? Why should the hospital be interested in working together? What evidence can you provide to support your case?

Clarify Values

- Be up front and clear about what your group or organization stands for.

Clarify Roles

- Clarify the roles that each partner or organization will play in the collaboration. Revisit this topic regularly.

Anticipate Resistance

- Be prepared to encounter resistance from some hospital staff members (or members of your own organization).

Be Flexible

- Collaboration may challenge the ‘normal’ way of doing things for you and others. It will expose those involved to new perspectives and practices that differ from what is considered to be ‘standard practice’.
- Keep an open mind. Think carefully about the degree of flexibility your organization is willing and able to accept.

Communicate Strategically

- Be strategic in terms of how you communicate with hospital staff, management and board members. Use language that fits with their organizational values and interests, but without unduly compromising yours.

Don't Use the Hospital as a 'Life Raft'

- The transfer of resources (material or in-kind support) from the hospital can be a key benefit (and a reasonable expectation) of collaboration for community organizations that have fewer resources and less institutional power than hospitals. However, community groups may wish to carefully consider their boundaries and not partner solely for the purpose of gaining material resources.
- The dependency that comes with over-reliance on the hospital may compromise your ability to negotiate effectively when disagreements or new opportunities arise.

Collaboration success factors

Once a collaborative has been initiated, energy must be invested in establishing and maintaining effective processes of working together. Throughout this guide, we have stressed that there is no simple formula for successful collaboration. Even so, the experiences of those who have participated in hospital-community collaboration offer insights into the success factors that are important to this kind of work. The following suggestions and questions, adapted from THCU (2001) and Heady (2000), can foster discussion among participants to strengthen collaboration and increase your chances of success.

1. Establish and maintain trust and mutual understanding among partners.

- Does the group encourage honest discussion about how collaboration serves both personal and organizational interests?
- How well do participants understand each others' perspectives, values, and ways of doing things?
- Do participants openly acknowledge the different types of power that each organization brings to the table?
- For suggestions regarding how hospitals can build trust working with community groups, see “Advice from the Field” on page 21.

2. Build consensus.

- Is there agreement on the nature of the issue/problem as well as the purpose and specific objectives for the collaboration?
- Has the group developed a shared vision and set of values? (see the sample partnership agreement in Appendix E).

3. *Maintain open and frequent communication.*
 - Are there various channels for communication that reflect the diverse styles and preferences of participants?
 - Do those involved feel that they are up-to-date on the collaboration's activities and accomplishments?
 - What kind of opportunities do participants have to interact and get to know each other (e.g., during unstructured time in meetings and through social gatherings)?
 - Do those involved recognize and appreciate diverse styles of interaction?

4. *Ensure adequate representation from the necessary partners.*
 - Are the right people at the table given the collaboration's objectives? Who else should be there?
 - Is there a balanced and diverse membership representing individuals who may be end users of services or who will be directly affected by the collaboration's activities?
 - How much decision-making power do participants have within the organizations or groups that they represent?

5. *Encourage participants to be receptive to new ideas and sharing (of resources, ideas, etc).*
 - Is there a safe forum for the exchange of ideas, concerns and questions?
 - Are diverse views and opinions actively sought out?

6. *Manage conflicting positions with regard to policy.*
 - Do participants seek compromise on key process and structure issues?
 - Do participants have opportunities to provide honest input? Are problems and conflict acknowledged and discussed openly?
 - Is there a procedure in place for resolving conflicts?

7. *Integrate competing perspectives and modes of practice.*
 - Do participants feel that they are generally 'on the same page' in terms of the collaboration's goals, values, and ways of working together?
 - Is there a clear and effective process for collective decision-making?

To learn more: The group *Campus Community Partnerships for Health* has developed nine principles to facilitate and strengthen partnerships between communities and institutes of higher learning. These principles are also relevant to hospital-community collaboration. They are summarized in Appendix D.

Working with Diverse Communities

In successful collaborations, diverse perspectives are recognized and valued. Significant diversity in ethno-racial background, ability/disability, and sexual orientation is a characteristic of virtually all Ontario communities (see Appendix G: 'Why Consider Diversity') and must be addressed in order to ensure that community work is equitable and inclusive. The text box below offers a few useful ideas to help you engage diverse community members in your work.

In hospitals, we discovered through our research that work with specific ethno-racial communities was often delegated to staff members who came from similar backgrounds to those communities. While these individuals might be better positioned to understand and work with these communities, it is also true that they may not always wish to be typecast in these roles, and that doing so is not always the best way to sensitize all members of the hospital community to the needs and issues of diverse community members (Poland et al, 2004). Workers in health care and other institutions need to be sensitive to their own privilege and ways of operating that might reinforce power imbalances between their organization and community members.

Therefore, all organizations are encouraged to actively promote equity, inclusion and accountability in all aspects of their work. To do this, you may need to hire staff with skills and experience in developing organizational diversity initiatives. There are also many resources available to assist organizations in this process (including organizations such as CAMH that offer organizational training in equity and access issues).

Working Effectively with Diverse Communities

“... it is critical to involve the community in the initial planning phase of partnership programs. One of the best ways to build the bridges across distrust and misinformation is to recruit, whenever possible, trusted advocates from within the community. These community members will be able to establish valuable connections and provide insights into the community dynamics, cultural beliefs, and practices. However, it also is important to be aware that this community member may not be sensitive to cultural issues solely by virtue of being a member of that group. There are many variables to be considered, including economic status, social class, age, and experience. To avoid any pitfalls, converse with as many members of the community as are accessible, identifying the elders, leaders and trusted advocates. Often, these community members may lead you to the informal opinion leaders. These people are often not those identified as community leaders, but in many cases have more influence than the identified leaders.

Inviting the community representatives as guests to the institution for a variety of events can be a first step in the right direction. Acquiring knowledge is a two-way process. The community can give information, but it also needs information about the institution, its culture, policies, procedures, services, and resources.”
(Source: SenGupta, CCPH, 2000)

Recommended Resource: The Ontario

Health Communities Coalition has developed a resource to assist community organizations in the process of becoming more inclusive of diverse community members. *Inclusive Community Organizations: A Tool Kit* can be downloaded from <http://www.healthycommunities.on.ca/publications/ICO/index.html>

See also: Eichler, M. & Burke, M. A. (2006). The BIAS FREE framework: a new analytical tool for global health research. *Canadian Journal of Public Health*, 97(1), 63-68.

3.6 Evaluating Collaboration: How are we Doing?

Because collaborative work is complex and time-consuming, it is important to regularly assess how well your collaborative effort is doing and whether it is making progress towards its intended goals. Note that evaluation is not just about measuring results. It can also be used to examine processes and procedures, engage stakeholders, and create mutual understanding among participants. Conventional approaches to evaluation often focus on criteria which can be easily measured (e.g., rates of hospital admissions). These approaches may not apply very well to collaborative work because this kind of work often has multiple (short and long-term) goals and it involves processes that are often complex and unpredictable. Many of the previously described keys to successful collaboration are the kinds of ‘intangibles’ that are difficult to measure such as trust, enthusiasm, openness/curiosity, and valuing the experiences and insights of diverse others. Also, it can take a long time for the collaborative work to show tangible results.

The evaluation of collaborative initiatives requires attention to both process and outcomes. In some cases, it may be tricky to distinguish between the two because the process is often part of the outcome in community work (Boutilier et al, 2001). Still, it is important to define and monitor key milestones as well as multiple indicators of success. In other words, avoid defining ‘success’ too narrowly, if possible.

Process evaluation is concerned with practices and activities undertaken as part of the collaboration. Process indicators are used to monitor the progress of your work and to show that change, however modest, is occurring, e.g., in the quality of relationships or in collective capacity of participants (Boutilier et al, 2001). The following are examples of process measures (adapted from Community Tool Box, 2003):

- Community/partner involvement (e.g., number, diversity, frequency of attendance, turnover);
- Planning products (e.g., written objectives, partnership agreements, establishment of committees or advisory groups that contribute to the collaboration);
- Financial resources (e.g., new funding to address local health issues);
- Services provided (e.g., classes, programs, workshops, educational reports, publications);
- Benefits to participants (e.g., individual skill development, expanded social networks, sense of empowerment)
- Advocacy activities (e.g., letters to politicians, depositions at City Hall)

Outcome evaluation considers the impacts your efforts. Potential outcome measures may include the following:

- New or modified services or programs (e.g., a parenting class, community dental clinic);
- New or modified practices (e.g., local merchants display signs describing the penalty for selling cigarettes to minors and the need for proper identification);
- A new or modified policy (e.g., city bylaw to reduce vehicle idling or ban pesticide use);
- Improved health outcomes among specific populations (e.g., lower rates of TB and Hepatitis C in a high-risk neighbourhood) (*adapted from: Community Tool Box, 2003*).

Finally, it is essential to set aside time for celebrating your achievements, even modest ones. In community work, small, incremental successes and milestones are often overlooked but may be significant stepping-stones towards more substantial changes. Making an effort to recognize these milestones can enhance the commitment and confidence of participants.

Recommended resource: The *Wilder Collaboration Factors Inventory tool* is a survey that can be used to assess various aspects of your collaboration. The Inventory questionnaire can be found and also completed on-line at http://surveys.wilder.org/public_cfi/index.php.

3.7 Sustaining Collaboration

Our field research found that sustainability of collaboration is a real challenge for both community and hospitals. As the staff compliment becomes leaner, people are often reassigned to other critical tasks with little notice, and continuity of relationship building may be disrupted. People move on. The fact that hospital-community collaboration tends to be informal, relationship-based, and not highly visible within the organization makes it particularly vulnerable.

A lot of time and effort usually goes into establishing a successful collaboration. It is therefore important for collaborators to plan for the sustainability of their work. This involves anticipating potential opportunities and barriers that may arise. There are many reasons to sustain the work of your collaboration:

- Partners have figured out how to work together effectively and can build on their relationships to make even greater progress while leaving many of the hurdles behind.
- Many years are typically required to see the effects of the collaborative initiative. Preferably, the group's work will continue until certain objectives are achieved, thereby validating their work.
- If the effort dissolves prematurely, it may be more difficult for the individual participants to attempt collective action in the future because they may have lost credibility and this may lead to confusion in the community about the identity and purpose of future projects (TCHU (2001, p. 38).

“I think the worst thing you can do in a consumer partnership is create something and then lose it. So if you don't value it enough in the first order to develop a method for sustaining it, don't do it in the first place because it's just another loss. And I think it destroys your...I mean it has tremendous potential to destroy your credibility” (Hospital Senior Manager)

And yet, sustainability should not necessarily be seen as an end in itself. From time to time, it can be constructive for participants to discuss the circumstances under which the collaboration would be discontinued (e.g., because it has achieved its main goals or because key members are no longer involved). Sometimes, established networks or partnerships need to adjust their mandate or reorient their work completely in order to stay relevant to participants and the communities they serve.

Also, bear in mind that the group's activities will typically fluctuate over time based on various factors (e.g., profile of the issue(s) being addressed, availability of funding) and the interest and availability of participants. The sustainability of collaborative work also depends on the capacities and commitment of the individuals and organizations involved. Therefore, paying attention to factors noted throughout this guide (building trust, leadership, effective communication, etc.) will help the collaboration thrive in the long-term.

The extent to which the collaboration's activities have become “routinized” over time is also a predictor of program sustainability (Pluye et al.2004a). Organizations routinize collaborative activities by allocating resources, adapting to the community context, and adopting supportive values and rules (e.g., by introducing formal plans and policies) (Pluye et al., 2004b). Also, activities may become standardized in order to meet policy guidelines or institutional standards (e.g., hospital accreditation).

The key message here is that collaboration requires supportive structures to be sustainable. This does not mean that formal collaboration is always the best path to choose. As discussed in section II, less formal working relationships may be more appropriate for certain purposes, even if they are relatively short-lived and are not explicitly supported by organizational and institutional structures.

IV. Concluding Thoughts

This resource guide on hospital-community collaboration draws on field research (Poland et al, 2004) in the belief that, given the complex realities of collaborative relationships in the community, it is frontline practitioners who have the most expertise about how to get these off the ground. It is their voices, experiences, wisdom and advice that we have sought to uncover and make available for others. As such, our intention is that this guide and the resources that accompany it (e.g., many of the tools in the Appendices) will be a ‘living document’ that will be refined and added to as others begin to engage and work with it. We therefore seek your input on what resonates with your experience, what is useful and what is not, and what could be added in terms of tools and lessons learned from the field, from both hospital and community perspectives.

In closing, we emphasize the importance of also paying attention to the policy context for hospital-community collaboration. Policy can enable collaboration or it can get in the way by creating disincentives. Policy that enables hospital-community collaboration:

- Balances clarity of expectations (regarding responsibilities, desired outcomes) with **flexibility** about how to best achieve these
- **Builds on existing partnerships**, networks, alliances and collaborations (rather than re-inventing the wheel in a way that over-rides, side-steps or kills existing collaborative efforts)
- **Aligns incentives**, directives and accountabilities
- **Clarifies desired priorities** for how accountabilities in terms of diverse stakeholders and outcomes are to be balanced (cost issues, patient outcomes, equity considerations, population health)
- Focuses on **building capacity** for community health improvement
- Balances clinical/palliative care with attention to other **determinants of health**

We wish to emphasize that when it comes to collaborative community work there are limits to what can be learned from documents such as this. Ultimately, the most powerful learning comes from an active engagement in the field and from dialogue with diverse others (colleagues in other jurisdictions, potential and actual collaborators, etc). We encourage you to seek out informal mentors and like-minded colleagues who may already be clustered in existing networks or coalitions. Recent research suggests that it is in these informal (or sometimes more formalized) *communities of practice* that learning and innovation are most likely to occur.

Good luck!

V. Glossary

Asset Mapping: A map or understanding of community assets that begins with an inventory of the gifts, skills and capacities of individuals, followed by a similar list of community organizations (e.g., neighbourhood groups, cultural groups) and formal institutions (e.g., hospitals, health and social service organizations, schools, private businesses).

Community: The term community is dynamic and inclusive; “there is no one definition of community. Community need not be defined solely by geography. It can refer to a group that self-identifies by age, ethnicity, gender, sexual orientation, disability, illness or health condition. It can refer to a common interest or cause, a sense of identification or shared emotional connection, shared values or norms, mutual influence, common interest, or commitment to meeting a shared need” (CCPH, 2006).

Community Capacity: the ability of a community to organize itself to identify and solve problems. Building community capacity may involve providing training and support in areas such as: shared power, sustainability, leveraging resources, health education, promotion and communication (THCU, 2001).

Community Development: There are many different definitions of community development. The following two definitions capture many of the key elements associated with a community development approach:

- “Helping people to develop the skills they need, and removing the structural barriers that prevent them from achieving their full potential as members of the community” (Hoffman & Dupont, 1992)
- “The process of supporting community groups in identifying their health issues, planning, and acting upon their strategies for social action/social change, and gaining increased self-reliance and decision-making power as a result of their activities” (THCU, 2001).

Community Engagement: Involving local residents, patients and their families, and/or local community-based health and social service providers.....in health system governance (needs assessment, service planning & delivery, evaluation). Note that hospital-community collaboration can be much broader than this, focusing on determinants of health and not just health system governance.

Collaboration: Collaborations come in various shapes, sizes, and durations. They typically involve working relationships through which parties constructively explore their differences and seek out solutions that go beyond their own vision of what is possible. Formal collaborations (which may also be referred to as partnerships) are formed to *share* resources, risks and decision-making; they are usually longer-term and involve a high intensity of activities.

Empowerment: Like “community development”, this is another term that has been assigned many different meanings. A broad definition of this term is “a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing social and political environments to improve equity and quality of life” (Minkler & Wallerstein, 2002).

Evaluation: A systematic inquiry to inform decision-making, judgments and learning, i.e., a thoughtful process of asking critical questions, collecting appropriate information and then analyzing and interpreting the information for a specific use and purpose.

Health Promoting Hospital: A health promoting hospital does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the

aims of health promotion, develops a health promoting organizational structure and culture, including active, participatory roles for patients and all members of staff, develops itself into a health promoting physical environment and actively cooperates with its community (based on the Budapest Declaration on Health Promoting Hospitals. WHO, Regional Office for Europe, Copenhagen, 1991). For more information on this topic, refer to <http://www.hph-hc.cc>.

Health Promotion: The Ottawa Charter for Health Promotion provides a widely cited definition of health promotion as "the process of enabling people to increase control over, and to improve, their health" (WHO, 1986).

"Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion action" (OHPRS, n.d.).

Hospital-Community Collaboration (HCC): An arrangement where a hospital and one or more community-based organizations agree to work together to achieve shared goals or outcomes. HCC may be initiated by a hospital or by a community organization or group and possesses some or all of the following qualities:

- shared authority and responsibility (e.g., for the delivery of programs and services);
- joint investment of resources;
- shared liability or risk-taking;
- mutual benefits;
- shared information or decision-making.

Partnership: A term frequently employed to characterize an ideal (formal) relationship between organizations with respect to community action initiatives.

Social Determinants of Health: Health is determined by complex interactions between social and economic factors, the physical environment and individual behavior. These factors are referred to as determinants *of health*. They do not exist in isolation from each other. It is the combined influence of the determinants of health that determines health status. According to Health Canada (2003), the key determinants of health include: income and social status; social support networks; education; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture. See Appendix C for more information of Social Determinants of Health.

VI. References Cited

- Boutillier, M.A., Rajkumar, E., Poland, B.D., Tobin, S, Badgley, R.F. (2001). Community action success in public health: Are we using a ruler to measure a sphere? *Canadian Journal of Public Health*; 92(2), 90-94.
- Cauley, K. (2000). Principle 1, In K. Connors & S.D. Seifer, (Eds.), *Partnership Perspectives*. Issue II, Volume I. San Francisco, CA: Community-Campus Partnerships for Health.
- Community Campus Partnerships for Health (2006). *CCPH Principles*. Retrieved September 1, 2006 from <http://depts.washington.edu/ccph/principles.html>.
- Community Tool Box (2003). *Gathering Information: Monitoring Your Progress*. Retrieved August 28, 2006 from http://ctb.ku.edu/tools/en/sub_section_main_1364.htm.
- Germann, K., & D. Wilson (2004). Organizational capacity for community development in regional health authorities: A conceptual model. *Health Promotion International*, 19: 289-298.
- Health Canada (2003). *Population Health Approach. – What Determines Health?* Retrieved August 28, 2006 from http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html#key_determinants.
- Heady, H.R. (2000). Principle 9, In K. Connors & S.D. Seifer, (Eds.), *Partnership Perspectives*, Issue II, Volume I. San Francisco, CA: Community-Campus Partnerships for Health.
- Hoffman, K., and J. P. Dupont. (1992) *Community Health Centres and Community Development*. Ottawa: Health and Welfare Canada.
- Lyon, L. (1989). *The Community In Urban Society*. Toronto, ON, Lexington Books.
- Minkler, M. & Wallerstein, N.B. (2002). Improving Health Through Community Organization and Community Building. In K. Glanz, B.K. Rimer & Frances Marcus Lewis (Eds.) *Health Behavior and Health Education*, (pp. 279-311). San Francisco, CA: Jossey-Bass.
- Nutbeam, D. & Harris, E. (2004). *Theory in a nutshell* (2nd Ed.) New York: McGraw-Hill.
- OHPRS (nd). Health Promotion On-line Course. Retrieved August 29, 2006 from <http://www.ohprs.ca/hp101/main.htm>.
- Pluye, P., Potvin, L., & Denis, J. (2004a). Making public health programs last: conceptualizing sustainability. *Evaluation and Program Planning*, 27, 121-133.
- Pluye, P., Potvin, L., Denis, J., & Pelletier, J. (2004b). Program sustainability: focus on organizational routines. *Health Promotion International*, 19 (4), 489-500.
- Poland, B. et al., (2005). Working at the margins or leading from behind?: A Canadian study of hospital-community collaboration. *Health and Social Care in the Community*, 13(2), 125-135.
- Poland, B. et al., (2004). [A Study of] *Hospital Involvement in Community Action Summary of Research Findings*. Unpublished document.
- Poland, B., L. Fell, et al., (2001). We're Hired by the Hospital but We Work for the Community: Examining Hospital Involvement in Community Action, *Hospital Quarterly*, Spring 2001, 52-58.

- SenGupta, I. (2000). Principle 5, In K. Connors & S.D. Seifer, (Eds.), *Partnership Perspectives*, Issue II, Volume I. San Francisco, CA: Community-Campus Partnerships for Health.
- Stern, R. & Green. J. (2005). Boundary workers and the management of frustration: a case study of two Healthy City partnerships. *Health Promotion International*, 20(3), 269-277.
- The Health Communication Unit (2001). *Overview of Sustainability*. Centre for Health Promotion, University of Toronto.
- The Health Communication Unit (2006). *Evaluating Health Promotion Programs*. Centre for Health Promotion, University of Toronto.
- Westley, F., Zimmerman, B. & Patton, M.Q. (2006). *Getting to Maybe: How the World is Changed*. Random House Canada.
- Winer, M. & Ray, K. (1994). *Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey*. Saint Paul, Minnesota: Amherst H. Wilder Foundation.
- World Health Organization (1986). *Ottawa Charter for Health Promotion*. Retrieved August 28, 2006 from <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html>

VII. Appendices

- A. Recommended Resources
- B. Summary of Hospital Involvement in Community Action research findings
- C. ‘Social Determinants of Health: Why Do They Matter?’ (Fact Sheet)
- D. Partnership principles checklist
- E. Sample Partnership Agreement
- F. Sample hospital policy on external partnerships
- G. “Why Diversity?” Fact Sheet
- H. Tips for Evaluating Collaborative Initiatives

Appendix A: Recommended Resources

The following resources provide additional information on collaboration and related topics. Most of these are relatively accessible on-line or in print. When using these resources, be careful to adapt the tools and advice to your specific circumstances.

Asset-Based Community Development Institute (ABCD)

<http://www.northwestern.edu/ipr/abcd.html>

The Asset-Based Community Development Institute (ABCD), established in 1995 by the Community Development Program at Northwestern University's Institute for Policy Research, is built upon three decades of community development research by John Kretzmann and John L. McKnight. The ABCD Institute has produced many practical resources and tools for community builders to identify, nurture, and mobilize local assets.

Coming Together – Building Collaboration and Consensus

<http://communitycollaboration.net/>

This website is a concise, accessible introduction to what collaboration is and how it helps. Pete Peterson, a collaboration specialist working in Idaho, answers basic questions, such as “why collaborate?” and “what does collaboration look like?” He also offers a helpful online presentation (requires Flash). Peterson also provides a page of links to other resources about collaboration, offering information both general and specific.

Community-Campus Partnerships for Health

<http://depts.washington.edu/ccph/>

Campus Community Partnerships for Health has developed nine principles to facilitate and strengthen partnerships between communities and institutes of higher learning. The CCPH Partnership principles are reproduced in Appendix D of this guide. Their *Partnership Perspectives* publications outline these partnership principles and offer practical advice from experienced practitioners (these can be downloaded in pdf format from the site).

Community Tool-box

<http://ctb/ku/edu>

The Community Toolbox has more than 6,000 pages of practical information on over 250 different topics related to community development. Topic sections include step-by-step instructions, examples, checklists and related resources.

Community Organizing and Community Building for Health

Edited by Meredith Minkler, 2005, Rutgers University Press, <http://rutgerspress.rutgers.edu/acatalog/catalogbody.html>

Written from a public health perspective, this book offers a wealth of insights into the process of community building and organizing. Topics covered include community assessment and issue selection, working within and across diverse groups and cultures, and building and maintaining effective coalitions.

Health Canada: An Inclusion Lens—Workbook for Looking at Social and Economic Exclusion and Inclusion

<http://www.ifsnetwork.org/uploads/inclusion-lens-workbook-2002.pdf>

Before community-members can collaborate, they must be included. This workbook, provided by Health Canada, will help groups and organizations determine how inclusive they are, and identify ways to improve if necessary. Collaboration can become a closed loop very quickly if it doesn't actively involve members of many different communities, who may come with different perspectives or ideas. Inclusiveness makes collaboration more effective and truly engages community.

The Health Communications Unit

<http://www.thcu.ca/infoandresources.htm>

The Health Communication Unit (THCU) provides training and support related to health communication, health promotion planning, evaluation, policy change and sustainability. There are many comprehensive and accessible resources and tools that can be downloaded from the THCU website.

Hospital Involvement in Community Action Research Study

www.hospitalcommunitycollaboration.ca

The findings of the Hospital Involvement in Community Action study were published in the journal *Health and Social Care in the Community* (2005, volume 13, no. 2). An early article examining hospital involvement in community action was published in *Hospital Quarterly* (Spring 2001).

Human Resources and Social Development Canada – Community Development links

<http://www.hrsdc.gc.ca/en/gateways/topics/cyd-gxr.shtml>

At this site, you will find links to a variety of resources related to community development. Two resources in particular will interest readers of this guide: *The Partnership Handbook* and *The Community Development Handbook* cover many of the topics covered in this guide in greater detail.

Ontario Prevention Clearinghouse: Dynamic Partnerships

<http://www.opc.on.ca/english/index.htm>

This tip sheet provides reflections, references and resources about health promotion partnerships. Follow links Home > Programs > HPRC > Resources > Dynamic Partnerships.

Wilder Foundation/Fieldstone Alliance

<http://www.fieldstonealliance.org/client/consulting/pages/collaboration.cfm>

Two practical manuals can be ordered from this site (*Collaboration Handbook* and *Collaboration: What Makes it Work?*). The Wilder Collaboration Factors Inventory can be completed on-line at http://surveys.wilder.org/public_cfi/index.php.

Appendix B: [A Study of] Hospital Involvement in Community Action: Summary of Research Findings

Despite a burgeoning literature on inter-agency collaboration in general, **systematic documentation and analysis of the Canadian experience of hospital-community collaboration is almost completely lacking in the literature**, particularly as regards collaborations that address the determinants of health outside the hospital walls.

The goal of the (SSHRC-funded) Hospital Involvement in Community Action (HICA) study was to gain an understanding of how hospitals and community organizations work together on initiatives that address community health issues. Detailed qualitative case studies (in 4 Ontario sites: urban, suburban, rural and northern) and a telephone survey (of community organizations in the GTA) were employed in order to learn about the range of collaborations and working relationships that exist between hospitals and community agencies in Ontario, and the factors that influenced (enabled and/or hindered) the processes of hospital-community collaboration. Particular attention was paid to barriers and enablers at 3 nested levels of context: policy, hospital and community.

The following is a brief summary of the research findings:

- Hospitals and community organizations in Ontario are engaged in a wide variety of collaborations and working relationships from clinical foci to initiatives addressing the broader determinants of health, and from formal service agreements to informal working relationships and community development initiatives. To illustrate, we uncovered 88 collaborations in 4 case study sites, and this was by no means the full extent of what was taking place (there were no central inventories of such collaborations and often hospital staff were unaware of what community collaborations were taking place in other departments)
- The range of organizations that the hospital collaborated with was also extensive, from other health and social service providers (home care, VON, Meals on Wheels, CHCs, CCACs, youth drop-in centres, etc) to the private sector (e.g. McDonalds, a trucking company), new immigrant associations, churches, public health, local media, government, the police & fire departments, YMCA and many others
- Although it is widely acknowledged that community work is not their ‘core business’, many hospital staff and community representatives indicated that hospitals need to be thinking about how to work with community to better address patient care (before, during and after hospital stay), health promotion and community/population health. On the other hand, hospital involvement in community action remains often controversial and to some extent politicized: it has a troubled history in many local jurisdictions (past experiences of insensitivity and lack of skill on the part of hospitals, conflicts over turf, etc), it engenders hope as well as fear among community groups (concern over possible motives of the hospital), and although our data suggest it is much more widespread than typically acknowledged, it is still the case that these kind of collaborations are not typically on people’s ‘radar screens’ (either at a policy level nor indeed in most local communities) unless they have already been involved in such work in the past.
- The fiscal and policy environment is generally not supportive of hospital involvement in community action, especially when it comes to looking beyond the hospital walls and beyond patient education and discharge planning. In particular, the ways in which hospitals are funded tend to discourage/penalize hospitals for HICA despite the obvious merits of many such collaborations. Increasing financial pressures reduce the leeway hospital administrators have for underwriting community work. The one notable exception (and it was only at a

- limited pilot stage when we were in the field collecting our data, so it was not a topic raised by many interviewees) is the embedding of community health into the CCHSA's new AIM accreditation standards
- The institutional culture of hospitals is not generally a supportive environment for community development practice
 - It appears that the extent to which HICA flourishes (or exists at all) crucially depends on the presence and ongoing enthusiasm/commitment of one or more 'champions' within the hospital. The loss of champions (through turnover, secondment to other tasks, or burnout) is likely to seriously compromise hospital-community collaboration
 - We observed two fundamental stances towards hospital involvement in community action: it was an overarching guiding philosophy articulating the work of the hospital (or an entire unit within a hospital) in two of the four case study sites; in the other two sites community collaboration was seen (by the hospital) as 'nice to do' if warranted in particular circumstances, one of several competing options/approaches to be evaluated on a project-by-project basis
 - The evidence from our in-depth case studies suggests that formal institutional mandates for HICA (embedded in mission statements, formal strategic plans, etc) is not by itself a guarantee this work will be undertaken or widespread, but it was widely considered important, not only in terms of 'legitimizing' rhetoric' (that staff could point to, to justify the work), but also as a precursor to more sustained commitment of resources. Indeed, we observed that institutional commitment to HICA helped to sustain some collaborative projects during times of financial and organizational stress, in at least some of the sites we investigated. Further, CEO support can also generate expectations for collaborative work, and foster an institutional culture in which collaborative work is seen as an acceptable mode of practice.
 - The momentum required to sustain HICA cannot be realized solely from management expectations and/or institutional endorsement. In order to effect change in institutional practices, senior management and CEO support for HICA needs to be coupled with investment in frontline staff who act as 'champions on the ground'
 - Hospital staff described the need to work on two fronts simultaneously (albeit with varying degrees of intensity over time, depending on their ability to bear fruit): (a) building the profile and legitimacy (and thus sustainability) of community work within the hospital, and (b) building trust and collaborations 'on the ground' in community
 - Sometimes described in terms of 'dual accountability', the tensions associated with these competing demands (to be responsive to community and to fulfill requirements set by the employer/hospital) were exacerbated by the often stark cultural differences between hospital and community. Considerable work was often required on the part of both parties to get hospitals and community organizations to the point where they could more fully understand the very different organizational culture, assumptions, and modus operandi of the other party
 - The majority of community organizations surveyed reported encountering one or more difficulties in their collaborations with hospitals, but they were also able to identify enabling factors (both within the hospital and from the community) and significant achievements, reported high levels of overall satisfaction, and reported that the experience of working together increased understanding (of the community by the hospital and vice versa)

For further information see our article in the journal Health and Social Care in the Community (2005, volume 13, no. 2).

Appendix C: ‘Social Determinants of Health: Why Do They Matter?’ (Fact Sheet)

The following fact sheet is adapted from a document prepared by the ‘Greater Toronto Area LHIN Diversity Working Group.’ It makes the case that Ontario’s Local Health Integration Networks (LHINs) should make social determinants of health a priority.

What are social determinants of health?

Social determinants of health are the social and economic conditions that influence the health of individuals and populations. Some of the best predictors of whether we stay healthy or become ill include income, housing, education, employment and job security, stress, social supports – what we now consider the social determinants of health (1). A wealth of evidence from Canada and other countries supports the notion that the socioeconomic circumstances of individuals and groups are equally or more important to health status than medical care and personal health behaviours (2).

How do social determinants of health affect diverse communities?

Some groups such as visible minorities, immigrants, Aboriginal people, and single parent families face substantial economic and social barriers that have significant impacts on health. Ways in which social determinants of health intersect with diverse communities include:

- **Poverty** - Adults living in poverty experience poorer health in almost all health areas including mental health, substance abuse or addiction (3). Poverty rates for immigrants that had been in Canada less than five years doubled between 1980 and 1995. In Toronto, the poverty rate of visible minority families increased from just over 20% in 1981, to 29.5% in 2001, in contrast to that of non-visible minority families which stayed steady at 12% (4).
- **Homelessness** - One in five individuals who are homeless suffer from both mental illness and substance abuse, and most are not receiving treatment (5). LGBTTT youth are disproportionately represented among homeless youth due to family and community rejection. About 40% of homeless youth in Toronto are LGBTTT (6).
- **Social exclusion** - denies individuals the opportunity to participate in the activities normally expected of members of their society. These inequalities arise out of oppression related to race, class, gender, disability, sexual orientation, immigrant status and religion. Social exclusion is associated with increased rates of premature death, depression, higher levels pregnancy complications and higher levels of disability from chronic illness (7). There is evidence of growing social exclusion in Canadian society, particularly for Aboriginal people, non-European immigrants and racialized communities. For example, recent immigrants from non-European countries are twice as likely as Canadian-born residents to report deterioration in their health over an 8 year period (8).
- **Unemployment** - Unemployed people have reduced life expectancy and suffer significantly more health problems than people who have a job (9). Job insecurity has been shown to increase depression, anxiety and heart disease (10). Aboriginal people and racialized groups are three times more likely than the average Canadian to be unemployed, despite the high credentials of many immigrants (11). The unemployment rate for women with disabilities is 74% in Canada (12).

Why adopt a social determinants of health approach?

In terms of the health of populations, it is well known that disparities – the level of inequality in social and economic status between groups within a given population - greatly affect the health status of the whole. The larger the gap, the lower the health status of the overall population (13). In other words, it is in our collective interest to bring about health equity.

Despite mounting evidence for the role of social determinants on health status, much of the work being done on prevention and management of diseases remains highly medicalized. As well, the focus of health care has been almost exclusively on individual risk factors, not on the structural or societal issues that impact health. A social determinants of health approach provides a more complete picture of why people become ill in the first place, and what it takes to restore their health. It considers equity and social justice as necessary components of good health care.

To address social determinants of health is to build the very foundation of a healthy society. As Ontario's health transformation agenda unfolds, we encourage policy makers to eliminate health inequities among different population groups by taking a social determinants of health approach in health care planning and delivery.

~~~~~  
*This fact sheet is presented by the GTA Diversity and LHINs Working Group. We are an ad hoc coalition of health-care providers and community-based organizations from across the GTA who are working to ensure that there is equity, inclusion and accountability at all levels of LHINs planning and implementation. Please contact the following individuals for more information:*

- *Angela Robertson, Sistering  
(416) 926-9762  
arobertson@sistering.org*
- *Kwasi Kafele, Centre for Addiction and Mental Health  
(416) 535-8501 ext. 6539  
kwasi\_kafele@camh.net*

## Fact Sheet References:

- (1) Raphael, D. (2003/02). Addressing the Social Determinants of Health in Canada: Bridging the Gap between Research Findings and Public Policy. Paper given at The Social Determinants of Health Across the Life-Span Conference, Toronto, November 2002; article in Policy Options, 35-44.
- (2) Evans RG, Barer ML, and Marmor TR. (Eds) (1994). Why are Some People Healthy and Others Not? The Determinants of Health of Populations. New York: Aldine de Gruyter.
- (3) Cairney, J., & Arnold, R. (1998). Socioeconomic position, lifestyle and health among Canadian Aged 18 to 64: A multi-condition approach. Canadian Journal of Public Health, 89(3), 208-212.
- (4) United Way of Greater Toronto and Canadian Council on Social Development (2004). Poverty by Postal Code. Toronto.
- (5) City of Toronto (2001). The Toronto Report Card on Homelessness, retrieved from <http://www.city.toronto.on.ca/homelessness/homelessnessreport2001.pdf>
- (6) Sherbourne Health Centre (2005). Document prepared by Anna Travers on statistics and facts of LGBTTTQ community
- (7) Wilkinson, R. & Marmot, M. (Eds.) (2003). *Social determinants of health: The solid facts*. Copenhagen: World Health Organization. Retrieved from [www.who.dk/document/E81384.pdf](http://www.who.dk/document/E81384.pdf)

- (8) Galabuzi, G.- E. (2004). Social exclusion. In D. Raphael (Ed.), *Social determinants of health – Canadian perspectives*. Toronto: Canadian Scholars' Press Inc.
- (9) Health Canada, *What Determines Health?* (2001) supra note 4 online: Health Canada <http://www.hc-sc.gc.ca/hppb/phdd/determinants/>.
- (10) Polanyi, M., Tompa, E. & Foley, J. (2004). Labour market flexibility and worker insecurity. In D. Raphael (Ed.), *Social determinants of health – Canadian perspectives*. Toronto: Canadian Scholars' Press Inc.
- (11) Galabuzi, G.- E. (2004). Social exclusion. In D. Raphael (Ed.), *Social determinants of health – Canadian perspectives*. Toronto: Canadian Scholars' Press Inc.
- (12) Disabled Women's Network Ontario (2004). *Fact Sheets on Women with DisAbilities*. Retrieved from <http://dawn.thot.net/fact.html>
- (13) Wilkinson, R. & Marmot, M. (Eds.) (2003). *Social determinants of health: The solid facts*. Copenhagen: World Health Organization. Retrieved from [www.who.dk/document/E81384.pdf](http://www.who.dk/document/E81384.pdf)

## Appendix D: Partnership Principles Checklist

---

|                                                                                                                                                                                                                         |                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| 1. Partners have agreed upon mission, values, goals and measurable outcomes for the partnership                                                                                                                         | <input checked="" type="checkbox"/> |
| 2. The relationship between partners is characterized by mutual trust, respect, genuineness and commitment.                                                                                                             | <input checked="" type="checkbox"/> |
| 3. The partnership builds upon identified strengths and assets, but also addresses areas that need improvement.                                                                                                         | <input checked="" type="checkbox"/> |
| 4. The partnership balances the power among partners and enables resources among partners to be shared.                                                                                                                 | <input checked="" type="checkbox"/> |
| 5. There is clear, open and accessible communication between partners, making it an on-going priority to listen to each need, develop a common language, and validate/clarify the meaning of terms.                     | <input checked="" type="checkbox"/> |
| 6. Roles, norms, and processes for the partnership are established with the input and agreement of all partners                                                                                                         | <input checked="" type="checkbox"/> |
| 7. There is feedback to, among and from all stakeholders in the partnership, with the goal of continuously improving the partnership and its outcomes. Partners share the credit for the partnership's accomplishments. | <input checked="" type="checkbox"/> |
| 8. Partnerships take time to develop and evolve over time.                                                                                                                                                              | <input checked="" type="checkbox"/> |

Source: *Community Campus Partnerships for Health*  
 For more info, see <http://depts.washington.edu/ccph/principles.html>

## **Appendix E: Template for Partnership Agreements\***

---

The purpose of the template is to help partnerships to identify terms and conditions of an agreement that may be important to consider. The agreements will need to be negotiated with partner agencies who are likely to bring different experiences, perspectives and priorities with respect to necessary terms and conditions.

### **Background & Mandate**

- Specify how the partnership was initiated, identify who is funding the partnership, state the priority need/issue to be addressed, and the target population(s) to be served.

### **Purpose of the Partnership Agreement**

- Identify what the partnership agreement proposes to do, and who it is applicable to, for example:
  - *The purpose of this partnership agreement is to document arrangements between the lead agency and partner agencies.*
  - *All parties agree to be guided by the terms and conditions set out in this agreement.*

### **Partnership Values & Guiding Principles:**

- If possible, clarify the values and/or guiding principles that govern the partnership, for example:
  - *Communities will be active partners in the project, and will be supported to participate in various project phases.*
  - *All activities and practices will uphold the principles of diversity, equity, anti-oppression, respect, and inclusiveness.*
  - *Project partners will have any equal voice in decision-making and equal voting privileges.*

### **Project Outcomes, Activities, and Timelines**

- Clearly state the shared outcomes and activities that all parties will endeavour to achieve.
- Outcomes are the expected accomplishments, for example, *To increase knowledge of community resources.*
- Activities are the specific actions that will contribute to the identified outcomes, for example, *Deliver parent workshops.*
- Specify the duration of the partnership, and the anticipated dates for specific outcomes/activities.

### **Roles & Responsibilities**

- Specify the roles and responsibilities of the following:
  - Lead/Trustee Agency
  - Partner Agencies
  - Advisory/Steering Committee
  - Working Groups
  - Partner agency staff

- Staff hired by the partnership
- Clarify reporting relationships.
- Develop a terms of reference for any project committees (e.g. Advisory/Steering Committee, and Working Groups) detailing:
  - Committee/Group Mandate
  - Areas of responsibility (e.g. strategic planning, project activities, project evaluation, etc.).
  - Process to elect/appoint Chair/other designates, and to address absenteeism of members.
  - Permission to establish other committees to fulfill their responsibilities.
  - Quorum (e.g. 50% +1 of the members must be present in order for the meeting to take place).
  - Frequency of Meetings.
  - Declaration of conflict of Interest

### **Policies & Procedures**

- Identify the policies and procedures that agency and partnership staff will adhere to. For example, the partnership may wish to identify particular policies and procedures for the partnership, or it may simply state that the policies and procedures of the lead/trustee agency will govern the partnership.
- Policies/procedures might include: staff hiring, supervision and training, conflict of interest, anti-discrimination, access and equity, and media and public relations.

### **Inter Agency Communication**

- Identify the frequency of meetings between partner agencies (consider advisory committee meetings and working group meetings) and specify who is responsible for initiating meetings, setting meeting agendas, and chairing/facilitating these meetings.
- Specify how partners will communicate between meetings (e.g. by e-mail or fax, providing all members are included in correspondence).
- Suggest how representatives will maintain ongoing communication within their own organizations to that their Board, Management, Staff and Volunteers are clear about project objectives and responsibilities.

### **Decision-Making Processes**

- Clarify how ideally the partnership will make decisions regarding the partnership, including representatives and committees that are responsible for facilitating decision-making, and procedures to be followed by these individuals/committees.
- For example:
  - *The Steering/Advisory Committee will strive for consensus in all of its decisions. In instances where consensus is not possible, the Chair can request that an issue be put to a vote where each partner is entitled to one vote and a simple majority will decide the outcome.*
  - *Decisions must have the agreement of a majority of all Project Partners (not merely a majority of those present at a meeting).*

- *A regular meeting schedule will be established, and agendas will be circulated at least 2 days prior to each meeting. Each agenda will include time for new business arising where members may bring forward any issues of concern.*
- *Any project partner may request additional meetings by providing a minimum of one week's notice to all project partners.*
- *In emergency decisions, the Lead Agency will have the responsibility to make decisions on behalf of the partnership (e.g. responding to emergency occurrences), providing they have made a reasonable attempt, wherever possible, to involve project partners, and as long as the mandate, values and objectives of the partnership aren't compromised by the decision.*

### **Resolving Conflicts & Complaints**

- Identify a process to resolve conflicts in a productive way, for example:
  - *Invite project partners, staff and volunteers to deal with conflict in a positive way by naming, sharing and discussing issues as they arise, and taking all steps necessary to resolve issues.*
  - *Where possible, project partners will attempt to resolve conflict at the operational/working group level.*
  - *Project partners share equal responsibility to bring unresolved issues of conflict or instances of unfulfilled partner responsibilities to the Advisory/Steering Committee for resolution. In the event that such issues are not brought forward, the representative from the lead agency will be responsible for bringing issues forward to the Committee.*
  - *Parties should address conflicts involving 2 or more individuals/agencies in a face to face meeting where the conflict/complaint is named and described, and where a mutually acceptable solution is negotiated. Options include:*
    - *The Steering/Advisory Committee will convene a meeting to address any conflict/complaint in an open fashion.*
    - *The Committee will form a sub-group that will be responsible for managing the conflict resolution process.*
  - *Conflicts and complaints should be documented (in a general way – without reference to names or complainants) by the Project Coordinator and/or the Advisory/Steering Committee for purposes of reporting to the relevant Management and Program Committees, and where applicable to Board Members/Management in the partner agencies. Discussions aimed at resolving disputes between individuals should be kept confidential at all times..*
- Identify the process to resolve conflicts that can't be resolved using the above process, for example:
  - *A neutral person/agency will be appointed to facilitate a conflict resolution process.*
  - *Decisions arrived at through this process will be final.*

### **Addressing Proposed Changes to the Partnership**

(e.g. termination of partnerships, project enhancements/proposals for funding, & membership changes)

- Identify process to withdraw from/to terminate the partnership, for example:
  - *Project partners will provide a minimum of 3 month's written notice to the Steering/Advisory Committee regarding their intention to withdraw from the partnership, and will complete any outstanding reporting and service delivery commitments.*
  - *The lead agency will provide a minimum of 3 month's written notice of their intention to withdraw from the lead agency role or the partnership itself, and will continue to act as the lead agency for the project until a process of changing the lead agency is completed with the funder.*
  - *Instances where project partners are not maintaining their commitments to the project will be brought forward to the Steering/Advisory Committee for discussion and conflict resolution if required. Any monies already received or all monies received must be returned to the lead agency if this agreement is terminated before the date of termination agreed upon.*
- Identify process to enhance/expand the existing partnership, for example:
  - *Proposals to enhance/expand the existing partnership (e.g. seek additional funding to address new objectives, or to serve larger numbers of clients) will require discussion with the Board and Management of each of the partner agencies. Such enhancements will only be pursued if the lead agency, and partner agencies confirm that they have the support of their individual agencies to proceed.*
  - *Proposals that seek to address objectives that are part of the existing partnership agreement should be discussed with the current funder before proceeding.*
- Identify the process to add members to the partnership, for example:
  - *The Steering/Advisory Committee will review written letters of intent from any partners wishing to join the partnership; will determine that the prospective partner shares the core values of the project; and will decide upon their inclusion as an Associate or Project Partner based on how their participation will enhance the project objectives and effectiveness.*

### **Finances & Administration**

- Specify who is responsible for setting and changing the project budget.
- Indicate who is authorized to make spending decisions once the budget is set.
- If applicable, clarify how and when partner agencies will receive payments for services rendered/ expenses incurred (e.g. terms of payment, and documentation required).
- Indicate who will have responsibility for providing accounting services.
- Specify how administrative support for the partnership will be provided.
- Outline how the partnership will address a budget deficit, for example:
  - *The assumption of the Steering/Advisory Committee is that there will be no deficit because Agency Partners will have to live with assigned budget funds (Budget revisions may be proposed to the Steering/Advisory Committee through working groups and/or project staff/coordinator).*

### **Evaluation Plan**

- Indicate who is responsible for initiating and conducting the evaluation.
- Outline the critical indicators of success, and the appropriate tools/mechanisms to measure these (NOTE: These should link with the proposed work plan).
  - *The Steering/Advisory Committee will develop a detailed evaluation protocol which will be used consistently for all Centre activities and services, regardless of site.*
- Specify when and how this will take place.
- Clarify who will participate (e.g. partner agencies), and what their roles and responsibilities will be. For example:
  - *Service providers are responsible for providing data to the lead agency according to the identified data element definitions and established timelines.*
- Identify how the Steering/Advisory Committee, and the Boards/Management of individual partner agencies will monitor and respond to the results of the evaluation.
  - *In an effort to continually improve services, the Steering/Advisory Committee, and Partner Agencies will monitor program operations and examine client satisfaction of programs. Improvements will be incorporated into programs on an ongoing basis.*
  - *One Committee meeting every six months will be dedicated to a partnership review where emerging issues/concerns will be discussed.*

### **Involvement of Program Participants and Community Members**

- Identify how community members or program participants will participate in program planning and evaluation. For example:
  - *The Project Coordinator will have the responsibility to convene and support a Program Committee comprised of Associate and Community Partner representatives and program participants. This committee will identify program and service-specific concerns and broader issues of concern in the target community.*
  - *Program participants will provide feedback at regular intervals via client satisfaction surveys.*

### **Signatures**

- Designated representatives of lead and partner agencies (Executive Director and/or Board Chair) will sign the partnership agreement.
  - *By signing this partnership agreement each agency in the partnership agrees to comply with the terms and conditions set out in this document.*

**\*Source: Heather Graham Consulting Services ([h.graham@sympatico.ca](mailto:h.graham@sympatico.ca))**

## Appendix F: Sample hospital policy on external partnerships

---

### Hospital-Community Partnership Policy

(Date)

**Authorization date** This policy was authorized by *(insert name of agency/hospital)* Advisory Committee on *(insert date approved, and revision dates)*.

*NOTE: This sample policy was developed by an Advisory Committee that included both internal and external stakeholders (e.g. Board, staff, partner agencies, clients, potential clients, etc.).*

**Distribution** The Partnership Policy will be distributed to:

- Advisory Committee Members
- Agency/Hospital Staff
- The Board of Directors of *(insert name of agency/hospital)*
- Other relevant funders and partner agencies

**Purpose** *(Insert name of agency/hospital)* vision and guiding principles require a positive attitude toward co-operation and partnerships. The purpose of this policy is to promote, guide and support creative, mutually beneficial relationships with community groups.

**Definition** In this policy, the term “partnership” means an arrangement between *(insert name of agency/hospital)* and a community group to work together and achieve goals that will benefit both partners.

Examples:

- delivering a service or program in a co-operative way
- taking joint action to educate the public on health issue
- developing a policy that will help both partners carry out their missions

**Key features and values** These are the key features of a partnership:

- The partners share power and decision making
- Each partner invests resources such as time, money and knowledge
- The partners share the risk, responsibility and liability
- There is trust and respect between the partners
- *There is validation of cultural knowledge, practices and experiences*
- The arrangement takes advantage of the strengths of each partner
- The arrangement recognizes the needs and interests of each partner

| <b>In this policy</b> | <b>Topic</b>           | <b>Page</b> |
|-----------------------|------------------------|-------------|
|                       | Overview               | 1           |
|                       | Partnership Principles | 2           |
|                       | Partnership Procedures | 3           |

## Partnership Principles

*(NOTE: The specific principles identified should be relevant to the agency/hospital and its stakeholders. A participatory process that invites feedback from stakeholders – based on their experience with partnerships to date – is encouraged.)*

---

**Integrity** The partnership will maintain the standards, principles and values of *(insert name of agency/hospital)*.

---

**Compatibility** Partnerships will be compatible with the mandate and values of each of the partnering organizations.

---

**Mutual benefit** *(Insert name of agency/hospital)* and its partners will set attainable goals, with outcomes that will benefit both partners. *(Insert name of agency/hospital)* will select and balance partnerships so that all stakeholders whose interests are significantly affected are represented and involved.

---

**Clear communication** *(Insert name of agency/hospital)* will manage its partnerships in a way that is “transparent,” under terms that are clearly defined and accepted by both partners.

*(Insert name of agency/hospital)* will develop communication plans with its partners, with regular reporting of actions and decisions. Each partner will:

- take time to learn about each other’s mission, strengths and constraints
  - ensure awareness of any potential bias or conflict of interest
  - regularly report partnership actions, decisions and outcomes
  - develop a common language, validating and clarifying the words used in the partnership
- 

**Accountability** A Partnership Agreement will set out the accountability of each partner, including:

- responsibilities
- reporting relationships
- appropriate liability coverage

The partners will set up mechanisms to:

- monitor and evaluate the partnership
  - report on the progress of the partnership and actions taken
  - ensure regular consultation and feedback
- 

**Flexibility** In an effort to strengthen and improve partnerships, there will be room for both partners to re-negotiate and restructure their relationship. This might mean, for example, adding new partners, or taking on more staff.

The partners will update their goals and activities together, look at their experiences as well as new factors in the environment, and adjust the partnership to respond to these changes.

---

## Partnership Procedures

---

Initiating and planning *(Insert name of agency/hospital)* staff is responsible for researching and recommending new partnerships to the Advisory Committee, using the criteria set out in this policy. Their research will include:

- the reasons for initiating the partnership
  - the objectives and purpose of the partnership
  - the mandate and values of each of the participating groups
  - the key function the partnership is to play
  - the funding sources, needs and commitments
  - the names of all stakeholders who should be involved
- 

### Partnership agreements

*(Insert name of agency/hospital)* staff will recommend the degree of formality that will be needed in each partnership agreement. The agreement could be:

- a formal letter
- a contract

The agreement will:

- set out clear, realistic outcomes
  - describe the benefits for each partner
  - define the roles and responsibilities within the partnership
  - describe the evaluation process the partners have agreed on, including objectives, methods and time frames
  - set out the duration of the partnership
  - set out the process for resolving disputes, and the process for ending the agreement
  - provide for liability coverage for the partner organizations, their staff, and any volunteers involved
- 

### Approvals and monitoring

The Advisory Committee will approve and monitor the partnership agreement, using the criteria in this policy.

The Vice President, responsible for Risk Management *at (insert name of agency/hospital)* will review the partnership agreement to ensure there is appropriate liability coverage for the partner organizations, their staff, and any volunteers involved.

The Executive Director/CEO of *(insert name of agency/hospital)*, will sign the partnership agreement on behalf of the agency/hospital Board.

---

### Reference

For more information on community partnerships, please see:

Rodal A., Mulder N., "Partnerships, Devolution and Powersharing: Issues and Implications for Management." *Optimum*, Vol. 24, Issue 3, 1994.

---

## Appendix G: ‘Why Consider Diversity?’ (Fact Sheet)

---

The government of Ontario is transforming the provincial health care system. One of the key components of this transformation is the establishment of 14 Local Health Integration Networks (LHINs) that will coordinate, integrate and fund health care within specified areas. This new system will dramatically change the landscape of health care in Ontario. Why should LHINs make diversity issues a priority?

### ..... Because diversity is the demographic reality of Ontario

Ontario is distinguished as one of the most diverse and cosmopolitan areas of the world. This demographic reality compels the Greater Toronto Area (GTA) LHINs to address the access barriers to healthcare that diverse communities face.

- 13.5% of Ontarians live with a disability (Statistics Canada, 2001 Census)
- Almost half of Toronto’s population is immigrant and 42% report a language other than English as their mother tongue (Statistics Canada, 2001 Census)
- 10% of the adult population in Toronto is estimated to be lesbian, gay or bisexual (Toronto Public Health, 2001)

### ..... Because marginalized communities have poorer health outcomes

Many studies have found that minority populations have poorer health outcomes and experience differential treatment within the health system:

- Aboriginal youth suicide rates are about 6 times higher than the general population (1)
- Recent immigrants from non-European countries are twice as likely as Canadian-born residents to report deterioration in their health over an 8 year period (2)
- Twenty-two percent of homosexuals and bisexuals reported that they had an unmet health care need in 2003, nearly twice the proportion of heterosexuals (3)
- Black people are between 41 and 73 % less likely than white people to receive particular drugs for the treatment of HIV/AIDS, even after adjusting for age, sex, mode of HIV transmission, insurance, residence, income and education (4)

### What can LHINS do about this issue?

Communities are clear that a relevant, effective and forward-thinking health transformation agenda must be fully informed by, and responsive to, the diverse health needs and critical issues of our community. As Ontario’s health transformation agenda unfolds, we encourage policy makers to:

- Adopt a framework for social inclusion that considers and integrates the needs of diverse communities
- Ensure that diverse communities are reflected in community engagement processes, leadership, governance structures, funding and service access
- Set clear strategies to reduce health inequities related to race, gender, ethnicity, ability and sexual orientation
- Adopt the recommendations set out in the community submission to the Ministry, *Integration Opportunity: Access to Integrated Health Care for Racialized and Marginalized Communities*



*This Fact Sheet is presented by the GTA Diversity and LHINs Working Group. We are an ad hoc coalition of health-care providers and community-based organizations from across the GTA who strongly support equity, inclusion and accountability at all levels of LHINs planning and implementation. Please contact the following individuals for more information:*

*Angela Robertson, Sistering  
(416) 926-9762  
arobertson@sistering.org*

*Kwasi Kafele, Centre for Addiction and Mental Health  
(416) 535-8501 ext. 6539  
kwasi\_kafele@camh.net*

### **Fact Sheet References:**

- (1) Royal Commission on Aboriginal People (1995). Choosing Life: Special Report on Suicide among Aboriginal People. Downloaded from Health Canada's website: [http://www.hc-sc.gc.ca/English/for\\_you/aboriginal.html#9](http://www.hc-sc.gc.ca/English/for_you/aboriginal.html#9)
- (2) Statistics Canada (2005). *Dynamics of Immigrants' Health in Canada: Evidence from the National Population Health Survey in Statistics Canada*, in Healthy Today, Healthy Tomorrow? Findings from the National Population Health Survey.
- (3) Health Canada (2003). From Cycle 2.1 of the Canadian Community Health Survey (CCHS).
- (4) Morehouse Medical Treatment and Effectiveness Center (1999). A Synthesis of the Literature: Racial and Ethnic Differences in Access to Medical Care. Kaiser Family Foundation.

## Appendix H: Tips for Evaluating Collaborative Initiatives

---

The Health Communications Unit at the University of Toronto offers some useful tips for evaluating collaborative initiatives, based on health promotion principles:

- Ensure the meaningful participation of all partners and stakeholder groups in the evaluation process (planning, implementation and reviewing results).
- Focus on a broad definition of health in assessing your results, i.e., the extent to which the initiative addressed particular determinants of health.
- Assess the extent that the collaboration facilitated the process of empowerment, i.e., did participants achieve greater control over the conditions affecting their health and well-being as a result of (their participation in) the collaboration?
- Focus on the extent to which the collaboration builds on participants' strengths and assets, not just needs and deficits.
- Ensure that the results are shared with participants and community stakeholders in a way that meets their requirements (e.g., plain language, cultural appropriateness).
- Include evaluation measures focusing on the enablers/barriers to participating in the collaboration (e.g., transportation, meeting times, etc.).
- Use multiple evaluation methods (both quantitative and qualitative) to understand the complexity of collaborative work

*Adapted from THCU (2006). For more information on evaluating health promotion initiatives visit <http://www.thcu.ca/infoandresources/evaluation.htm>*



## PROJECT ACKNOWLEDGEMENTS

The **Hospital-Community Collaboration Knowledge Translation project** is supported by a grant from the **Change Foundation/Healthcare, Technology and Place Funding Alliance**. Team members included Dr Blake Poland (Principal Investigator), Heather Graham (Consultant), Julie Gilbert (The Change Foundation), Catherine Maule & Saddam Syed (Project Coordinators), Andrew Koch (Research Assistant), Heather Campbell (research/writing consultant), and Roshanak Mehdipanah (student volunteer). We would like to acknowledge the following Advisory Group members: Elaine Walsh, Anne-Marie Marcolin, Lorraine Purdon, Ted Mavor, Chris Rahim, Dan Clement, Karen Kuzmich, Joan Roberts, Adrianna Tetley and Russ Ford.

Much of this guide is based on original data collected as part of the **Hospital Involvement in Community Action (HICA)** research study. The HICA study was supported through funding received from a strategic initiative of the **Social Sciences and Humanities Research Council of Canada**. The core research team comprised Blake Poland (Principal Investigator), Leslie Fell, Heather Graham, Janet Lum, Elaine Walsh, and Paul Williams. Marie Boutilier and Natasha Greenberg provided valuable assistance with the collection and analysis of qualitative case study data. Stasey Tobin and Saddam Syed served as Project Coordinators during the course of the study.

We wish to warmly thank all those who graciously participated in the study as interviewees and those who facilitated our entry and orientation in the case study sites.

ISBN-10 0-7727-8733-6

ISBN-13 978-0-7727-8733-0

Dalla Lana School of Public Health,  
University of Toronto

Copyright 2008

cover design: michelle gay | steamworks.net  
printing: On Your Marks Print and Design

