Quality Improvement & Innovation Partnership

Advancing Improvement in Primary Healthcare in Ontario

COMMUNITY PARTNERSHIPS
RESOURCE GUIDE

January 2009

Amended December 2010

Ontario

ACKNOWLEDGEMENTS

The Community Partnerships Resource Guide for Family Health Teams has been developed by the Quality Improvement and Innovation Partnership (QIIP) to assist teams to establish effective partnerships with other organizations. This guide was developed for QIIP by Health Nexus Santé (www.healthnexus.ca) and their work and contributions are gratefully acknowledged.

During the development phase of the guide a number of Family Health Teams were contacted to share stories and examples of community partnerships they had established in their local communities. The assistance of the following is recognized:

- Etobicoke Medical Centre Family Health Team
- Credit Valley Family Health Team
- London Shared Care Pilot Initiative
- Rideau Family Health Team
- Six Nations Health Services
- PrimaCare Community Family Health Team
- Sherbourne Family Health Team
- South Algonquin Family Health Team
- Summervillle Family Health Team
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QIIP is funded by the Ontario Ministry of Health and Long-Term Care. The opinions expressed in this publication are those of the authors and do not reflect the official views of the Ontario Ministry of Health and Long-Term Care.

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INTRODUCTION / ABOUT THE GUIDE

To take effective action on chronic disease, it is important to understand that this responsibility is shared by both individuals and their communities. Creating supportive environments for health requires effective partnerships, which can produce strong leadership and a wise investment of resources.

This is particularly true for Family Health Teams (FHTs). To support the health of our clients, we need to draw on the resources of the whole community. Fragmented services and unconnected programs can result in duplication or a lack of relevant services, frustrating both client and provider. By bringing alignment to programs pursuing similar aims, however, program delivery and sustainability can be enhanced in ways that would be impossible if those aims were pursued separately.

This type of cooperation is already a big part of what Family Health Teams do. We connect with a variety of community organizations, which can include hospitals, pharmacies, pharmaceutical companies, long term care homes, and local public health departments. Plus, the daily teamwork inside a Family Health Team, which relies on effective collaboration among many disciplines on behalf of clients, already develops the processes and skills that can create strong partnerships with community organizations outside of Family Health Teams.

This Guide to Community Partnerships provides the tools to create or expand our relationships with our community networks of partners. It shows us different ways that community partnerships might manifest themselves, and ways in which these partnerships can be formed and maintained. The guide also encourages us to look beyond our current or usual networks to help our clients have the best health possible.

Above all, this guide emphasizes how important it is to collaborate. Seeded throughout are examples of Family Health Team initiatives rooted in collaboration. Whether they are loose and flexible structures or formalized groups, these partnerships create opportunities to achieve an impact beyond what would be possible as separate entities. When we connect the institutions and members of a community, we improve client care and outcomes, while supporting the well-being of our communities. This is not about adding work; it's about doing work differently.

WHAT ARE COMMUNITY PARTNERSHIPS?

It is hard to come up with a universal definition of what makes a community partnership, since their very nature is determined by the partners who participate in them. There is a broad spectrum of collaborations, ranging from loose associations to formal unions, which qualify as community partnerships.

In writing about partnerships, however, we have made some assumptions that apply to any type of community partnership. These include:

- Partnerships take time, skill and effort – on all sides.
- Power-sharing is necessary in partnerships – with some loss of autonomy.
- No partnership will work if it comes together only for funding purposes.
- Partnerships are beneficial to all partners involved.

More specifically, community partnerships can be defined by the degree of interaction. The level or intensity of the partnership depends a great deal on the need, goal or purpose.

You have a number of clients of your FHT who need physical exercise. You could:

- Refer them to community-based exercise programs through recreation services such as the local YMCA.
- Collaborate with recreation staff in the community to create a new drop-in program to meet your clients' specialized fitness needs.
- Join a multi-sectoral committee to expand access to bike paths and walking trails in your municipality

Ensuring that services are accessible and helpful to clients relies on all the different degrees of partnership and collaboration. Types of partnerships can range across the continuum from information sharing and service referral to system change. While the specifics of what's needed will vary from case to case, there are **three basic levels of engagement** that should be considered.

LEVEL 1— LINKS WITH LOCAL COMMUNITY SERVICES

It's one connection at a time and each connection leads you to another one.

Learning about our communities and locating appropriate resources for client and family referral are integral to interventions and treatment planning. Often, we move from our existing linkages to broader ones through an ongoing process of getting, giving and sharing information about the available resources and services.

We can think of examples of Community Care Access Centres (CCACs), hospitals, and public health units as key community service providers that can support coordinated access to care. Many FHTs

have excellent cooperation and working relationships with the local CCACs around meeting with physicians, finding resources and trying to coordinate services for individual clients.

Clearly, linkages must be established with these key groups. But it is also important to move beyond the familiar. If the challenges we face are complex, so too are the solutions. If the health solutions provided are to be effective, it may require Family Health Teams to endeavor outside their usual scope or established ways of working.

> My colleague and I went and sat in our local hospital's patient education programs to learn what the patients learn—and it's extensive. They were wonderful and shared many resources with us.

One way to seek out unexpected potential new partners is to **consider all the determinants of health**. For instance, the 2008 Annual Report of Canada's Chief Public Health Officer points out that many groups in our society, including Aboriginal populations, recent immigrants and those living in poverty, experience lower life expectancy than others. Some groups have higher rates of infant mortality, injury, disease and addiction, and some tend to have higher rates of obesity and overweight. Thinking of the root causes of health issues provides opportunities to focus on prevention rather than cure and may suggest different types of partners

> A woman who has recently arrived from Sri Lanka and has diabetes may also require culturally appropriate services to help her find transportation, access to healthy food, and job supports.

At this early stage of partnership, the association may be left informal. The most important thing is to draw on all the team members' experiences and networks. In this way, you can expand the knowledge base from which your decision-making can flow. It is worth remembering that clients may also have resources that they would not think to mention – unless asked.

Having linked to and coordinated with local community services, the possibility of deeper collaboration may emerge.

> Staff at the Six Nations FHT noticed that clients with positive FOBT results were waiting a long time after their referrals until they could have their colonoscopies. After connecting with local health organizations, the Six Nations FHT staff discovered the Brantford General Hospital has a colonoscopy clinic. Partnering with the hospital has resulted in wait time reductions for patient intake. The FHT staff is able to follow the clinic- and surgeon-preferred referral process to get the patient appointment.

LEVEL 2— COLLABORATIVE WORK WITH COMMUNITY PARTNERS

Short-term initiatives are a good way to test the waters with a potential community partner: start small, and then let it grow.

New connections bring different partnership opportunities. As groups get to know one another, they may begin to think of ways of working together. In most cases, these initial collaborations take the form of one-time events or short-term projects.

Over time, organizations that offer similar services can agree to collaborate, which, in addition to other benefits, allows clients to navigate the system more smoothly. Partnerships then become a part of community-building efforts, enhancing care and avoiding possible duplication of efforts.

> Early in 1999, concerned agencies, community members and groups came together to discuss the growing needs in East Scarborough. The primary concerns of this group were how services and supports could be brought to the people in this community, especially to those who have been marginalized and live in poverty. Two years of consultation and discussion resulted in The East Scarborough Storefront, a community-wide collaboration of more than thirty organizations.

As we pay attention to accessibility and culturally responsive approaches to primary care, the need to develop new relationships and partnerships in order to better reach, serve and involve particular client groups becomes clear. What may work for one client or group is not always appropriate for another. It is important that agencies be able to build relationships and trust through cultural competence.

Once groups have identified shared goals and established a good working rapport with each other, they may choose to take their collaboration to a different level.

LEVEL 3— DEVELOPING PARTNERSHIPS FOR CHANGE

The ability to achieve larger-scale impact through formalized partnerships beyond the health sector is powerful.

Action to support the overall health of our communities requires more resources than any one group can provide. Health care on its own cannot effect a long term change in the health of a community unless that community is able to alter the underlying conditions that influence its health, be it a shortage of adequate housing, a lack of nutritious food, inaccessible recreation, or any of the other determinants of health. These primary risk factors, at some point, need to be addressed.

Health and community groups in Windsor-Essex are in the early stages of forming a food security coalition to improve access to locally grown, healthy and affordable food.

To have a coordinated voice behind a community health issue requires that we try to look at systems as a whole, beyond separate and isolated parts. As Family Health Teams continue to develop and thrive, we can help build capacity for improved community health and speak with others on behalf of those who have less power and influence in the community.

WHY ARE COMMUNITY PARTNERSHIPS IMPORTANT TO FAMILY HEALTH TEAMS?

Community partnerships help create a well-linked system – improving health by expanding options and support for clients and families. As we become more connected with community programs and services, and begin to work as partners, we offer our clients much more *together* than we ever could on our own.

Chronic diseases such as cardiovascular diseases, diabetes, mental illness and some cancers can be prevented and managed through lifestyle supports, changing health inequities and in the way that health care services are provided.

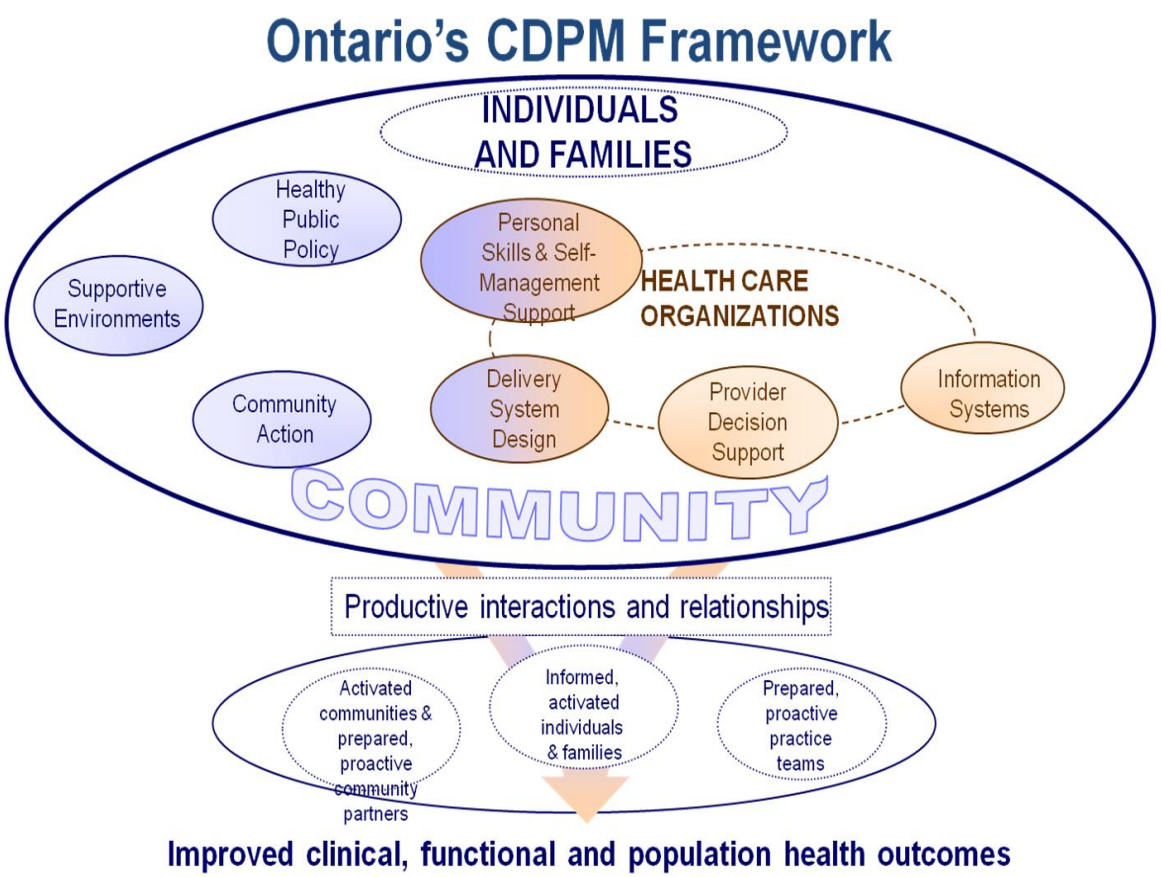
We want to connect people to supports and services that can help them to quit smoking, lose weight and eat more nutritious food—*and* we need to link to services that help people on low incomes to find healthy food and accessible programming.

Summerville FHT is testing planned care using a multidisciplinary clinic approach for clients with diabetes. The clinic model provides an education focus surrounding lifestyle changes (exercise and weight management).

For physical activity, the Summerville FHT clinic provides information about services available in the community and refers patients to the Sweet Success program offered through the Diabetes Education Centre (DEC). The DEC is in partnership with local Parks and Recreation to provide programming. Newly diagnosed and complex (multiple co morbidity) patients with diabetes are referred to the Diabetes Education Centre (DEC) at Trillium Health Centre to be co-managed.

Effective client self-management requires the support of a full range of services and providers working together. The Chronic Disease Prevention and Management Model (CPDM) helps us develop a systems-based approach to chronic disease, encouraging enhanced relationships with 'activated communities and prepared, proactive community partners'.

The CDPM model integrates aspects of prevention and health promotion into our chronic disease management efforts, portraying interdisciplinary teams that work directly with community supports and leadership to address chronic health concerns of clients. The CDPM reflects the porous border between the health system and community services; this becomes important as FHTs provide system navigation for clients and families. Partnerships occur at any and all points within the system to both encourage individual behaviour change and to address the systems issues that are needed to support health in communities.



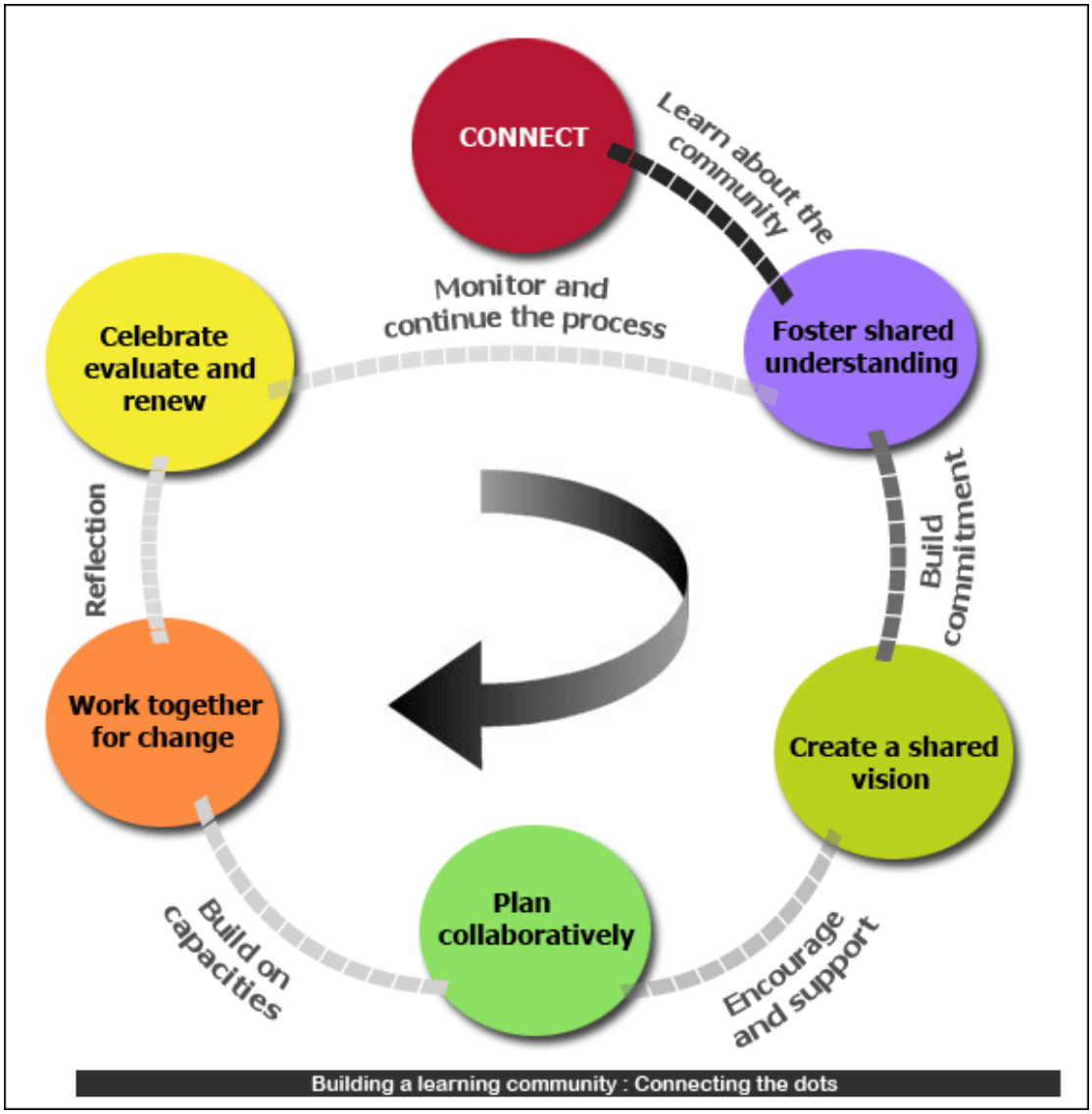
Adapted from the Chronic Care Model, McColl Institute of Health Care Innovation (www.improvingchronicillnesscare.org) and informed by the Expanded Chronic Care Model for British Columbia.

The following section highlights the steps to forming and maintaining the community partnerships that can improve clinical, functional and population health outcomes through productive interactions and relationships.

HOW ARE COMMUNITY PARTNERSHIPS FORMED AND MAINTAINED?

Building partnerships is complex and does not always follow a predictable pattern. The following are the ingredients of a successful partnership process, but while the order we suggest is a logical progression, in practice, we often end up moving back and forth between steps along the way.

The framework below helps to evaluate the process and the outcomes of partnerships.



STEP 1: CONNECT

The first step in connecting with others is finding them. While teams consider the known groups/resources available, take some time to think about 'hidden' assets that may be available. Some FHTs are producing newsletters to share information and to communicate beyond their own networks.

> Some Family Health Teams have started a monthly *Lunch & Learn* program where local community organizations come and talk about their services.

An interesting way to select targets for connection is to develop a list of what's out there -- an *asset map* of your community. Community asset-mapping is a health promotion approach developed in the United States by John Kretzman and John McKnight to help take stock of *all* of the resources in the community, which include local organizations, physical spaces, and community members who may be marginalized. Their Community Building Workbook (2005) offers worksheets and practical ideas on how to get started.

> The Canadian Diabetes Association is an example of a national organization that will connect you locally.

Many communities have online directories of community information and services available. Here are some places to begin:

- **The Family Health Teams Guide to Community Funding Partnerships and Program/Service Integration** (January 2006) introduces categories of potential community programs, services and partners to consider.
- **Association of Ontario Health Centres (AOHC)** provides links to the community health centre closest to you, and the wide range of networks and experience on collaboration and partnerships that they bring.
- **LHINS** connects to Ontario's fourteen Local Health Integration Networks, each of which is involved in gathering inventories of community services that can be helpful to Family Health Teams.
- **Community Care Access Centres (CCACs)** have inventories of community programs**.** One example is **www.communitycareresources.ca,** developed in partnership with the Toronto Central LHIN and the Central LHIN areas and expanding to other regions.
- **211Ontario.ca** is a province-wide initiative with links to community services in seven regions and growing.
- **Community Information Online Consortium** is a work in progress, but currently offers a partial list of links to online community databases in many regions of Ontario.

- **Prevent Stroke's database of community services** is a source of programs to prevent and manage chronic disease in your community.
- The **Ontario Health Promotion Resource System (OHPRS)** has links to more than twenty health promotion organizations working to support partnerships. Many include community resources to prevent chronic disease and support health.

Community information is also available through libraries (both public and hospital patient libraries), community information services, First Nations groups, local politicians' offices, the United Way, self-help groups, neighbourhood associations, faith groups, community gardens and community centres, literacy groups, service clubs, parks and recreation, seniors' groups, chambers of commerce and other local associations.

Many areas have coalitions or networks that have formed to mobilize resources and coordinate activities around particular health concerns (e.g. heart health, addictions and harm reduction, physical activity) or around healthy communities generally, and they may already be in contact with Family Health Teams.

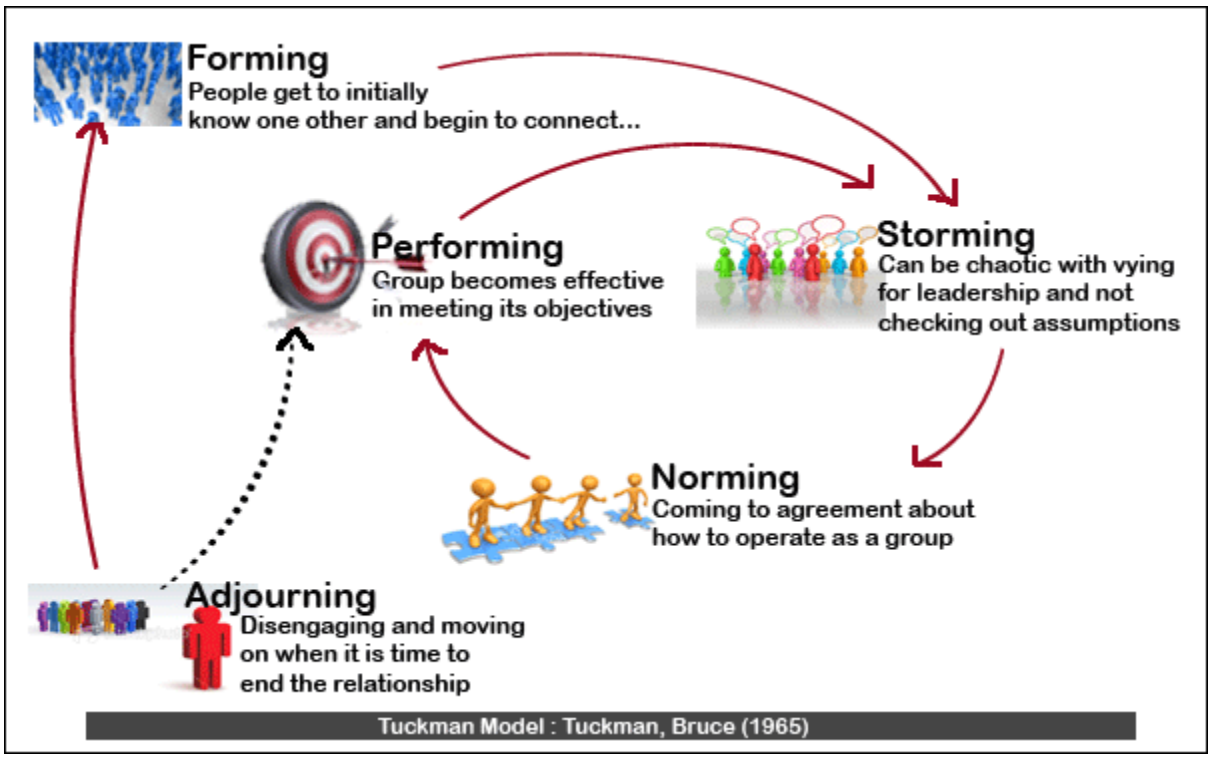
Also, remember to include clients and their families as part of this search. Clients are often connected to sources and services beyond their own current health needs. To that end, a number of initiatives through community health centres or public health groups are using citizen or community engagement in the actual assessment, planning and development of programs and services.

Timmins FHT has established some links with community optometrists to ensure reporting of eye exams with all diabetes patients. Previously, the only way the MD or NP would know that their patient had an eye exam was if they reported it. The partnership they are establishing will allow optometrists to send a report of eye exams to the identified primary provider after each eye exam visit. It removes the onus from the patient to remember to report, and it verifies that it was in fact a retinopathy screen that was the purpose of the visit.

STEP 2: FOSTER SHARED UNDERSTANDING

It is important right at the start to come to a basic understanding about the purpose of coming together. Whether there is a need to cooperate across services only to share information or there is an opportunity to develop more formal relationships across stakeholders, the time taken to forge a common purpose determines the process and structure.

Working together is about the dynamics of relationships and it may be helpful to refer to Bruce Tuckman's famous stages of group development (1965): Forming, Storming, Norming, Performing, and Adjourning (this fifth stage was added later).



These stages of group development assist groups to recognize where they are as they form and change. In these early stages of collaboration, conflicts will inevitably come up. In any partnership, there will be conflicting agendas, turf issues, and/or misunderstandings. It's important to bear this in mind, as conflict is normal and can even be healthy – so long as it's dealt with properly.

A rural FHT was happy to discover that there was a stop-smoking program in a neighbouring town. They were surprised, however, when one day they received an angry call from the community program director, asking the FHT to stop referring so many patients!

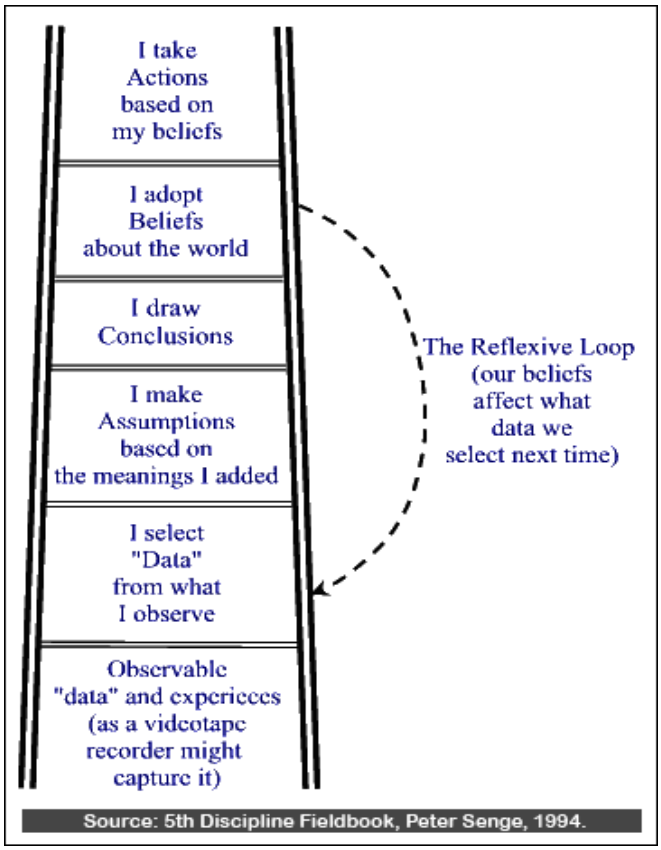
Consider ways of talking together about limitations and expectations. Partners are typically balancing personal agendas, their organizations' welfare, and the shared goal of the collaboration; at times, a partner may even have joined the partnership to protect against a perceived threat. Taking account of the community's well-being as well as one's self-interest requires clarification of expectations, attention to roles and responsibilities and processes that support a collaborative commitment.

When FHTs cross the boundaries of more than one LHIN and more than one CCAC, different terminology, systems and protocols can cause communication headaches!

Tensions often highlight people's passions, which can be a positive element in partnerships. Supported by our organizational cultures, however, partners often try to *manage the conflict*,

allowing many things to go unsaid. A cycle sets in where partners form opinions but do not know how to validate them.

The *Ladder of Inference* helps us examine our own thinking – our pathways of assumptions and observations that support our beliefs about a situation. With time and trust, participants in collaboration may want to learn how to make these pathways more visible to each other without immediately drawing conclusions that can lead to spoken or unspoken conflict.



STEP 3: CREATE A SHARED VISION

Sharing a vision of the desired outcome is important. Because collaborations initially attract groups with common/similar missions, often much is taken for granted or assumed without taking time to find out more about each partner's interests.

'Creating a shared vision' often evokes images of daylong retreats, wordsmithing and pieces of paper that do not get looked at again! Yet we know that taking some time to ensure that there is a mutual purpose and understanding about the intent of the relationship supports productive interactions. Indeed, at various stages throughout the work, you will find it helpful to keep a focus on what the partnership is about.

It is also important to explicitly determine shared values. In order to do this, prepare a partnership for action by asking "What guides us?" Look for and determine the principles and values that will guide the partnership. Articulating these values supports working with a shared, clear intent. Some would say that collaboration itself is a value. It is important to explore areas of common ground for a while, building trust. Often, we assume potential partners have similar values, but it is an important exercise to formally list and acknowledge the values that need to be reflected in the partnership.

Shared values of a partnership initiative might include some of the following:

- Comfortable and welcoming environment
- Commitment to marginalized and low-income populations
- Responsiveness to community needs
- Reflecting diverse communities
- Integrity and transparency

Timmins FHT is establishing a plan to improve the documentation of self-management goals. A partnership with the (DEC) Porcupine Diabetes Information and Services and the FHT has developed a plan to share any established self-management goals with the primary care provider. With documented goals of patients within the electronic medical record, the provider can give ongoing self-management support. It also provides confirmation to clients that communication between health care professionals is taking place.

STEP 4: PLAN COLLABORATIVELY

To support a more seamless health care system, partnerships must foster and sustain open communication and ensure that information between all parties is shared freely and often. We all know that this is not an easy task.

While planning is obviously crucial, a balance must be struck; sometimes, meetings become the primary focus of partnerships. As the partnership develops, people need to be able to contribute and feel part of the collaboration between meetings as well. If the partnership's decision-making and communication are participatory, meeting formats can be altered to support group thinking, planning and acting.

We started a drop-in group on stress management in partnership with a local community centre. The point was that most of the work was done over the phone and on email…we didn't really have that many meetings!

As for leadership, it sometimes is centred in a lead partner, and at other times, leaders emerge only as the purpose, structure and work to be done are developed. Either way, all involved are accountable for results.

Shared leadership encourages flexibility while maintaining momentum and allowing the exploration of new ideas (and partners) to inform decisions. The same leadership qualities of collective responsibility that enhance effective team performance within Family Health Teams also support effective partnerships with others.

London Shared Care Pilot (SCPI) has developed a partnership with London InterCommunity Health Centre. Together, they are providing a psycho-educational group intervention for children and families who are patients of SCPI physicians.

The InterCommunity Health Centre provides an R.N., Dietitian (Diabetic Educator) and a program assistant. SCPI provides a Social Worker and the space to hold the group meetings. Together, they provide children and their parents with information, professional and community support, so that group members learn more about their individual health needs and develop strategies (which might include nutrition, exercise, and stress management) to

STEP 5: WORK TOGETHER FOR CHANGE

Partnerships bring together a wider variety of perspectives than you would find working independently. To achieve effective change, partners must consider the wider, overall impacts of their decisions and actions.

It is also important to remember that participatory decision-making is not always about reaching consensus. Here are three guidelines to consider for effective group decision-making, adapted from the Facilitator's Guide for Participatory Decision-Making (2006):

- When it is time for a decision, everyone knows where everyone stands.
- Partnerships need group decision-making that brings out the wisdom, experience and skills that reside in the partners – thus, inviting difference.
- A problem is not considered to have been solved until everyone who will be affected by the solution understands the reasoning.

South Algonquin FHT is exploring a partnership with a local community centre in Whitney to provide space for group diabetes education classes. There is limited community space where patients can be physically active during the inclement weather. The community centre has exercise equipment, space and recreational programs.

The partnership would benefit the FHT by providing a larger space for the FHT-led diabetes group classes, and would benefit the community centre because community members who might otherwise not use the facility may be more inclined to do so, having been invited through the group diabetes education classes and encouraged by peer support.

STEP 6: CELEBRATE, EVALUATE AND RENEW

A successful collaboration is a process, not a destination. Even once some success has been achieved, it is important that the partnership continue to be nurtured and developed.
There are factors that are shown to be strongly associated with successful partnerships. Monitoring, measuring, learning about and improving our partnerships require evaluation of how well the partnership is functioning. To that end, ask the following questions:

- Is the overall goal being met?
- How has each partner linked to that overall goal?
- Are partners engaged in a sustained and committed way?
- Is there inclusive decision-making?
- Are partnerships using actual data to develop their activities?

The results of partnerships can also be evaluated in terms of client outcomes, using indicators that correspond to the goals of each initiative.

Partnership evaluation measures for client outcomes might include:

- Increased client satisfaction
- Increased frequency of physical activity
- Improved metabolic control

Take time to share the progress of the work and to share the credit on an ongoing basis as part of a continuous learning cycle.

The "Wellness for Tots" program is a pilot project the Stratford FHT is participating in with the Perth District Health Unit (PDHU).

This initiative focuses on improving community health by screening 18-month- and 36-month-olds to provide data for any developmental and nutritional concerns within this specific population sub-group.

The model is one of community partnership with sharing of resources that are beneficial to both partners. The FHT provides the target population base and performs the assessments required. Information is transferred to the PDHU for further analysis and interpretation.

Benefits include improved community relations with other health providers. Sharing resources provides the potential for a larger population base to be utilized. Resource sharing also provides reference points for developmental and nutritional patterns within the patient population to ensure patients are within accepted standards, and to provide statistics that will enable the FHT to improve current standards.

CONCLUSION

It is our hope that this guide has provided you with the information and tools you need to begin or improve the process of collaboration.

Creating community partnerships can, of course, seem like a very daunting task. When you consider all the factors that must be present to build a healthy community, trying to be comprehensive about our approach can seem challenging. But as with any worthwhile task, the key is taking reasonable steps towards your goal. As the examples included throughout this guide demonstrate, partnerships are yielding substantial rewards.

By being open to collaborations, and fostering them with the help of the information in this guide, you can streamline client services and improve health outcomes. In terms of finding common ground, that's something everyone can agree on!

And, remember to take time to check out links and resources on the following pages to further explore partnerships and the factors that support working together.

LINKS AND RESOURCES

- **Addressing the Determinants of Health Together: A Resource Guide for Hospital-Community Collaboration**. University of Toronto, 2008.
  http://www.hospitalcommunitycollaboration.ca
  This guide provides an orientation with research findings, quotes, and practical tools to help assess or negotiate potential working relationships.
- **Alliances, Coalitions and Partnerships: Building Collaborative Organizations**. Joan Roberts, New Society Publishers, 2004. http://www.joanroberts.com/acpbcobk.htm
  Aimed at non-profits but widely applicable, this book provides a step-by-step understanding of how to create effective collaborations, alliances and partnerships with outside agencies and organizations.
- **A Review of Collaborative partnerships as a strategy for improving community health**. Roussos, ST, Fawcett, SB *Ann Rev Public Health*, 21:369-402 (2000)
  http://www.ncbi.nim.nih.gov/pubmed/10884958
  Collaborative partnerships (people and organizations from multiple sectors working together in common purpose) are a prominent strategy for community health improvement. This review examines evidence about the effects of collaborative partnerships on (a) community and systems change (b) community-wide behaviour change, and (c) more distant population-level health outcomes. We also consider the conditions and factors that may determine whether collaborative partnerships are effective. The review concludes with specific recommendations designed to enhance research and practice and to set conditions for promoting community health.

- **Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets**. John P. Kretzman and John L. McKnight, ACTA Publications, Chicago, 1993. http://www.northwestern.edu/ipr/publications/community/buildingblurb.html
  This guide to what the authors call "asset-based community development" summarizes lessons learned by studying successful community-building initiatives in hundreds of neighbourhoods across the United States. It outlines in simple terms what local leaders can do to locate, assess and mobilize assets in communities.
- **Collaboration Math: Enhancing the Effectiveness of Multidisciplinary Collaboration**. The Prevention Institute, 2003.
  http://www.preventioninstitute.org/pdf/collab_math_web_020105.pdf
  This paper describes Collaboration Math, a tool developed to help individuals and groups representing different disciplines, organizations or constituencies work together effectively. This practical tool was designed to make key differences and similarities within groups explicit, so that they are more likely to succeed in the challenging work of building and sustaining collaborations.
- **Collaboration: What Makes It Work – A Review of Research Literature on Factors Influencing Successful Collaboration**. 2nd Edition. Paul W. Mattessich, Marta Murray-Close, Barbara R. Monsey, Fieldstone Alliance Publishing, 2004.
  http://www.fieldstonealliance.org/productdetails.cfm?SKU=069326
  The resources in this book include: a working definition of collaboration; details of the twenty factors influencing successful collaborations; a handy one-page chart comparing the elements of cooperation, coordination, and collaboration; and practical suggestions for using the research in the report.
- **Collaborative Leadership in Public Health**. Leadership Development National Excellence Collaborative (USA), 2005.
  http://www.collaborativeleadership.org/index.html
  By their definition, collaborative leadership is leadership shown by a group that is acting collaboratively to solve agreed upon issues. This site offers tools, resources, and training information about collaborative leadership, with a special focus on developing public health leaders.
- **Community Health Collaboration Models for the 21st Century**. Bolton, L.B., Georges, C.A., Hunter, V., Long,O. & Wray, R., *Nursing AdmQ,* 22, 6-17.
  http://www.ncbi.nlm.nih.gov/pubmed/9624977
  The development of partnerships with physicians and other health professionals is a key strategy to improving the community's health. This article reviews the role of nurse leaders as advocates for health care improvement and leading community improvement efforts.
- **Creating and Maintaining Coalitions and Partnerships**. The Community Toolbox, University of Kansas. http://ctb.ku.edu/en/dothework/tools_tk_1.htm
  This part of the Community Toolbox provides a framework and supports for creating your coalition or collaborative partnership. Available support includes:
  - Outline for Creating and Maintaining Coalitions and Partnerships
  - Outline with links to tools and other online resources
  - How-to Information on Creating and Maintaining Coalitions and Partnerships
  - Example(s) of Creating and Maintaining Coalitions and Partnerships
- **Developmental sequence in small groups**. Bruce Tuckman, *Psychological Bulletin* 63:384-399, 1965. The article was reprinted in *Group Facilitation: A Research and Applications Journal*,

Number 3, Spring 2001 and is available as a Word document:
http://dennislearningcenter.osu.edu/references/GROUP%20DEV%20ARTICLE.doc.
This paper is the original source for the theory of the "forming, storming, norming, performing" stages of group development.

- **Developmental Stages in Public Health Partnerships: A Practical Perspective**. Laura E. McMorris, PhD, Nell H. Gottlieb, PHD, Gail G. Sneden, MA. *Health Promotion Practice* 6(2):219-226, April 2005.
  http://hpp.sagepub.com/cgi/content/abstract/6/2/219
  The authors observed the start-up of a state health department/multi-university partnership for the evaluation of the state's tobacco settlement pilot project using the lens of the Tuckman four-stage model of group development.
- **Dynamic Partnerships**. Ontario Prevention Clearinghouse (now Health Nexus), 2003.
  http://www.healthnexus.ca/our_programs/hprc/hprc_resources.htm#dynamic
  This tip-sheet provides reflections, references and resources about partnerships.
- **Evaluating Community Partnerships and Coalitions with Practitioners in Mind**. Frances D. Butterfoss, PhD, Vincent T. Francisco, PhD *Health Promotion Practice,* vol.5,No.2, 108-114 (2004)
  http://hpp.sagepub.com/cgi/content/abstract/5/2/108
  Evaluation plays a key role in developing and sustaining community partnerships and coalitions. We recommend focusing on three levels of coalition evaluation that measure (a) processes that sustain and renew coalition infrastructure and function; (b) programs intended to meet target activities, or those that work directly toward the partnership's goals; and (c) changes in health status or the community.
- **IAP2 Spectrum of Public Participation**. International Association for Public Participation, 2007.
  http://www.iap2.org/associations/4748/files/IAP2%20Spectrum_vertical.pdf
  This one-page table describes various levels of public participation and what they imply to the public, and also lists techniques that may be used at each level.
- **Networks and social capital: a relational approach to primary healthcare reform**. Catherine Scott & Anne Hofmeyer, *Health Research Policy and Systems* 5(9), 2007.
  http://www.health-policy-systems.com/content/5/1/9
  This article reviews the rationale for collaboration in health care systems; provides an overview and synthesis of key concepts; dispels some common misconceptions of networks; and applies the theory to an example of primary healthcare network reform in Alberta.
- **Partnership Self-Assessment Tool**. Center for the Advancement of Collaborative Strategies in Health
  http://www.cacsh.org/psat.html
  This tool was designed to help partnerships understand how collaboration works and what it means to create a successful collaborative process; assess how well their collaborative process is working; and identify specific areas they can focus on to make their collaborative process work better.
- **Tamarack: An Institute for Community Engagement**
  http://tamarackcommunity.ca/CL_index.html
  Tamarack is building a learning community on collaborative leadership: "The pervasive concept of leadership is that of the heroic leader – they have a vision, they assert it, they persuade us and they gain followers. Collaborative leadership turns that concept upside down - if we bring good people together in constructive ways, we will be able to push forward."

- **The Change Foundation's Health Integration Report**
  http://www.changefoundation.ca/
  This website shows how Ontarians want clearer, two-way communication among all the parts and players in our health system and better coordination of services.
- **The Collaboration Primer: Proven Strategies, Considerations and Tools to Get You Started**. Gretchen Williams Torres, MPP & Frances S. Margolin, MA (2003)
  http://www.hospitalconnect.com/hret/programs/content/colpri.pdf
- **The Development of an Evaluation Framework for Partnership Working**. Morris Atkinson, *The Electronic Journal of Business Research Methodology* 3(1):1-10, 2005.
  http://www.ejbrm.com/vol3/v3-i1/v3-i1-art1-atkinson.pdf
  The aim of this project was the design of a methodology to help evaluate the complexities of working in partnership and to assess the extent to which collaboration actually adds value in terms of both process and outcomes.
- **The 'How to' series**. Best Start: Community Action for Healthy Babies, 2000.
  How To Build Partnerships with Physicians
  How To Build Partnerships with Workplaces
  How To Build Partnerships with Youth
  How to Work with Coalitions
  http://www.beststart.org/resources/howto/pdf/PHYSICIANS.pdf
  http://www.beststart.org/resources/howto/pdf/WORKPLACES.pdf
  http://www.beststart.org/resources/howto/pdf/YOUTH.pdf
  http://www.beststart.org/resources/howto/pdf/COALITIONS.pdf
  A series of how-to guides designed for community-based agencies with helpful tips and suggestions on how to involve other groups.
- **The Partnering Toolbook**. Written by Ros Tennyson (2003)
  http://www.iblf.org/resources/general.jsp?id=49
  This book offers a concise overview of the essential elements that make for effective partnerships for sustainable development. It covers a range of issues, including partnering agreements, managing the partnering process, and sustaining partnering. Along with the book, a range of supporting materials and tools can also be downloaded. The book has also been published in English as well as a range of other languages.
- **The Partnership Handbook**. Flo Frank & Anne Smith, Minister of Public Works & Government Services, 2000.
  http://dsp-psd.pwgsc.gc.ca/Collection/MP43-373-1-2000E.pdf
  This book is intended to help people learn more about what partnerships are and to offer suggestions about how to be effective in them. Although the main emphasis of this handbook is on community-based partnerships, the information and processes are applicable to most partnership efforts.
- **The Partnerships Analysis Tool for Partners in Health Promotion**. John McLeod for VicHealth (Victorian Health Promotion Foundation, Australia).
  http://www.vichealth.vic.gov.au/assets/contentFiles/VHP%20part.%20tool_low%20res.pdf
  This resource assists organizations in developing a clearer understanding of the range of purposes of collaborations, helps to reflect on the partnerships they have established, and focuses on ways to strengthen new and existing partnerships by engaging in discussion about issues and ways forward. It is eight pages long, including an extensive checklist.

- **The Reality Underneath the Buzz of Partnerships: The potentials and pitfalls of partnering**. Francie Ostrower, Stanford Social Innovation Review, 2005.
  http://www.ssireview.org/pdf/2005SP_feature_ostrower.pdf
  Ostrower focuses on the frequent disconnect between funders' goals and their often-stringent partnership requirements: "My purpose here is not to criticize partnering, but to plead for greater realism about partnering's benefits and limitations. We must cease invoking partnering as a panacea and begin to treat it simply as one method among many for achieving a foundation's or a nonprofit's goals.
- **The Tension of Turf: Making It Work for the Coalition**. The Prevention Institute, 2003.
  http://www.preventioninstitute.org/pdf/TURF_1S.pdf
  This article deals with the term "turf," in this case meaning how the 'property' is divided up, who gets the recognition, and the resources—be they financial or political. Concerns about turf are natural and common within coalitions and should be acknowledged rather than ignored. Solutions to turf issues should aim to blend the pursuit of individual interests with the greater goals of the coalition.
- **The Wellesley Institute's Inter-agency Services Collaboration Project**
  http://wellesleyinstitute.com/interagency-service-collaboration-non-profit-sector
  Capacity Building Consultant Joan Roberts and the Wellesley Institute spent 2007 investigating collaboration in on-the-ground health and social service delivery. They explored the service delivery collaboration already happening in Toronto, as well as what the research literature says about which collaborations improve client health and service quality. Their full 234-page report is available as a PDF download.
- **What Determines Health?** Public Health Agency of Canada.
  http://www.phac-aspc.gc.ca/ph-sp/determinants/index.html
  This site lists and discusses the determinants of health, including social determinants.
- **Who is the Puzzle Maker? Patient/Caregiver Perspectives on Navigating Health Services in Ontario**. The Change Foundation Health Integration Report, The Change Foundation, June 2008.
  http://www.changefoundation.ca/docs/ChgFdn_Puzzle_Web.pdf
  This report presents snapshots of the experiences of patients and caregivers navigating the system in Ontario and shares their insights about what changes would help create a better integrated health-care system organized around their needs. Their input is instructive for everyone committed to improving the integration of health services in Ontario.
- **Working in Partnership – Recipes for Success**. Wild Rose Foundation, Alberta, 2001.
  http://www.wildrosefoundation.ca/partnershipkit/default.aspx
  This kit addresses both basic and comprehensive issues associated with partnering. It covers the steps involved in self-assessment, establishing compatibility, writing a partnership agreement, evaluating and enhancing the partnership, and conflict management.