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Institutionalization of Community Partnerships: The Challenge for Academic Health Centers

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Summary

Current public health priorities emphasize the elimination of health disparities, translational research, and transdisciplinary and community alliances. The Center for Community Health Partnerships is a proactive initiative to address new paradigms and priorities in health care through institutionalization of community-university partnerships. This report highlights innovative strategies and lessons learned.

Keywords

Community health partnerships; academic medical centers; community-based participatory research (CBPR); organizational change; health equity

Scholars committed to advancing knowledge development and improving health care outcomes through practice and research must work in the complex social, political, and cultural context of health care delivery. Evolving priorities include a renewed emphasis on prevention and management of chronic illness; elimination of health disparities; a call for reciprocal translational research models from the bench to the bedside and community settings and *vice versa*; and development of novel approaches for knowledge dissemination. The development and institutionalization of best practices for community based

participatory research (CBPR) are essential. Research agendas and innovations promoted by both the National Institutes of Health (NIH) Roadmap initiative¹ and NIH commitment to Clinical and Translational Science Award (CTSA)^{2,3} development increasingly require transdisciplinary and community alliances. Actualizing and sustaining authentic partnerships pose challenges at multiple levels (i.e., individuals, partnership dyads, organizations, and policy).

Previous reports have introduced models and lessons learned.⁴⁻⁷ Building on this work, this Report from the Field describes the evolution of a Center for Community Health Partnerships (CCHP) at the Medical University of South Carolina (MUSC). The report traces developments and evolving structures and processes in this Center's journey to institutionalize commitment to community-academic partnerships aimed at ultimately improving the health of our citizens and reducing disparities.

Evolution of the Center

Individual innovators at MUSC and local community organizations began working together decades ago to improve the health of community constituencies. Early on in this process, College of Nursing faculty and individuals from community health centers, schools, faith-based organizations, and other community organizations began collaborating to address health needs in underserved populations. South Carolina (SC), like other Southeastern U.S. states, has alarming rates of diabetes, obesity, hypertension, cardiovascular disease, infant mortality, and uninsurance.^{8,9} Notably, racial and ethnic minorities in SC are disproportionately affected by these conditions and experience worse health outcomes and differences in health care quality^{8,10}

Typically, these early collaborations evolved from individuals in the academic and community settings who had a prior history of working together, perceived each other as credible partners, and shared mutual interests. Community members contributed expertise on the contexts of the health issues and potential real-world solutions, while academic members contributed expertise on evidence-based approaches and evaluation strategies. Over time, these community-academic partnerships became more formalized with memorandum of understandings (MOUs) as funding was received for targeted projects. Many of these initiatives formed formal and informal advisory boards and/or coalitions.¹¹ Key characteristics of some of these initiatives are summarized in Box 1.

Strategic Plan to Build Skill and a Critical Mass

Overtime, a critical mass of researchers, clinicians, and community partners, who were dedicated to innovative community-academic partnership models, formed and the need for a concerted systems level approach to partnerships became evident. As part of an explicit Strategic plan, the College of Nursing's Dean and faculty began work to establish a formal center, the Center for Community Health Partnerships. Infrastructure development included expert consultation with other NIH funded centers; ongoing dialogue with community partners; and a series of capacity-building workshops on research methods and grant-writing. The College of Nursing committed to the hiring of an experienced health services research methodologist and a biostatistician.

A core group met weekly to adapt a research framework building on the lessons learned via early community collaborations. Consensus was reached to integrate common theoretical underpinnings and evidence-based practice.^{12–15} An ecologic perspective was adopted to guide the CCHP^{16–18} (see Figure 1). The Center for Community Health Partnership Model (see Figure 1) integrates and adapts the Chronic Care Model^{19,20} within a social ecological perspective. This perspective reflects the understanding that activity must function within and between many systems levels. CCHP activity reflects interaction of institutional environment (i.e., structures, policies, personnel), along with the community resource systems that are vital for the impact on policy and, ultimately sustainable health outcomes. Details of the CCHP Model are described elsewhere.^{15,21}

Promoting Infrastructure and Institutionalization

During the evolution of an organized CCHP, the core group generated mission and vision statements guided by its model. The College of Nursing provided financial resources for hiring a director, program coordinator, and administrative assistant. In view of the University's interest in community partnerships and the rich tradition of community–engaged activity in the College of Nursing, the CCHP received formal recognition as a University Center in 2008. Subsequent CTSA funding in 2009 further enhanced the University's position for broad impact by engaging in activities with the community addressing local and state health issues. The CTSA's are exemplars of a growing commitment by the NIH to support community engagement's role in translational research. The collaborative benefits facilitate the development of transdisciplinary and community research teams with unique and complimentary perspectives that create, implement, and translate effective culturally sensitive primary and secondary prevention and treatment interventions in community settings.

Figure 2 presents the fundamental structure, processes and outcomes of the CCHP. As noted, the goal is to activate a community of informed learners committed to the transformation and improvement of health outcomes for disparate communities. The processes targeted to achieve these goals include: 1) strengthening the capacity for existing and potential academic-community partnerships by developing systems-level communication exchange and dissemination mechanisms, identification and sharing of resources, and CBPR training and education; 2) facilitating partnerships that ask the appropriate questions and reach the appropriate people by coordinating and linking partners and resources, and providing partnership training, education, and support; 3) stimulating the discovery, translation, and dissemination of research in community settings with formal mentoring, training programs, interest group formation, and technical assistance; and 4) establishing mechanisms that sustain the progress of community-based initiatives with the institutionalization of processes and products.

To address the goals and enable the processes needed, the CCHP established a structure to organize activity. The structure of the CCHP consists of two advisory boards and five cores (administrative, partnership, mentoring and consultation, research and evaluation, and dissemination). Boxes 2 and 3 describe key roles and responsibilities of the two advisory

boards and five cores. Additional information about the CCHP organizational structure and operations can be found at <https://sctr.musc.edu/index.php/ce-about-us/organization>.

Implications and challenges in moving the CCHP forward

In moving forward and sustaining momentum, the CCHP faced several challenges. A major hurdle involves the implementation of institutional policies that are reflective of community equity in our projects, such as Institutional Review Board (IRB) approval processes for community co-investigators, processes for obtaining community consent prior to implementation of community projects, and equitable funding allocation to our community partners.

As a recipient of the inaugural NIH Partners in Health Award in 2008, the CCHP established internal supportive resources and processes to provide technical support to community partners who receive (or plan to receive) federal funding directly (i.e., build skills for obtaining federal-wide assurances, and negotiating facilities and administrative costs). This seemingly bureaucratic, but critical process required patient discussion and creative strategies between partners.

Other challenges include the facilitation of transdisciplinary buy-in and support, especially in a health sciences university where the majority of research is conducted at the bench or the clinical setting, as compared with the community. Due to tenure and promotion requirements and timelines, some academic colleagues, although interested in CBPR approaches, are concerned about the time commitment required to build community relationships and to develop processes to promote equity in research. Another challenge is to maintain the balance of community interests and needs with feasibility of CCHP resources and faculty time. Community members frequently request assistance from faculty with program evaluation, grant writing, and technical support for existing projects. Faculty often serve multiple roles in research, practice, and education, and lack time to “add on” new unfunded projects that may or may not enhance their academic trajectory and require considerable personal time. Currently, we do have several faculty who support these community requests as volunteer work during evening and weekend hours, yet the capacity to continue and/or expand this support is limited.

Although we have demonstrated improvement in linking partners together for better coordination and leveraging of their resources, we remain challenged with collecting and maintaining inventories of academic-community partnerships across the campus and community. A goal is to have a systematic database that is generated either by new IRB applications or grant funding that identifies academic-community partnerships. Community partners work together to collect a community inventory, yet multiple complexities of ownership and scarce resources among local community organizations are all ongoing challenges.

An exciting opportunity to meet several of these challenges is to further refine the integration of the CCHP objectives to align with the CTSA award funded in 2009. The CTSA Community Engagement Core provides resources that will assist with CCHP activities, yet further expands our objectives and expectations. We have obtained initial

success, as the CTSA funded our Community Engaged Scholars (CES) Program. The CES aligns objectives of the CCHP and CTSA Community Engagement Core with the mutual goal to increase the capacity of academic-community partnerships to conduct research. The CES is a 12-month fellowship for academic-community teams, with each team having at least one community partner and one academic partner. During the application process, the team develops a MOU and brief proposal describing a priority health issue and their proposed approach to address the issue. Members of the community advisory board (CAB) and scientific advisory board (SAB) review the applications. Six teams were selected during the first year, including inter-professional academic faculty from five of our six colleges and members from nine community organizations. The teams are provided didactic training on CBPR (monthly), mentorship (academic and/or community), and pilot funds for a formative CBPR project. The planned competencies of the teams at the end of one year are to: 1) understand the concepts and components of CBPR; 2) apply CBPR principles in the conduct of research; 3) incorporate CBPR principles and approaches in grant proposals; 4) communicate with audiences in both academic and community settings about CBPR principles and components; and 5) implement a pilot CBPR initiative. A task committee that includes academic and community members as faculty and mentors has developed the CES program. Institutional support has been received with this new innovative program as evidenced by CTSA funding in year one, and additional intramural funds for the next four years.

The immediate challenge now is sustaining and growing the CCHP during a period of significant dwindling resources, tight federal research funding, and increasing pressures on community organizations and leaders. It is clear that the CCHP must continue to be a critical element of the university's strategic plan into the next decade. Faculty have been recruited and hired based upon their interest and expertise in community health. Student projects and programs are focused on supporting one of the many community-based programs. Clinical practice activities have developed models of care that reflect the work of the CCHP. Transdisciplinary collaborations that build on existing community-based research and have the potential to increase the overall health impact will be explored and sought. Just as academic health centers support the fundamental resources needed for basic and clinical research (e.g. labs, space, supportive structures such as Clinical Trials Office), infrastructure support from the larger university is also needed for community partnerships.

In summary, the Center for Community Health Partnerships has been a proactive initiative from the College of Nursing to address new paradigms and priorities in health care. It has served to focus faculty research and practice initiatives and to provide institutional direction for strategic planning with the goal of impacting the health of our region. As a university designated Center, the CCHP reflects a transdisciplinary approach to research that is consistent with national directions. We will continue to evolve, creating unique opportunities to expand upon existing community alliances and capacity. The potential is high given a key component of MUSC's strategic plan, that is, to "promote community-campus partnerships in the public and private sector to reduce health disparities through education, research, and practice."

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Box 1

Exemplars of Community Partnered Initiatives

Project Name/Date Initiated/Major Goals	Population of Interest/Community Partners/Advisory Board or Coalition	Funding	Impact and Outcomes	Current Status and Challenges
Racial and Ethnic Approaches to Community Health (REACH) 2010 (1998) Decrease/eliminate health and health care disparities related to diabetes	AAs diagnosed with and/or at risk for Type 2 DM Multiple community partners including local clinics, hospitals, faith based, public and nonprofit organizations/MUSC/REACH coalition	Centers for Disease Control and Prevention (CDC) \$850,000 to \$1.2 million annually × 10 years	<ul style="list-style-type: none"> Decreased disparities in testing for diabetes complications Reduction in diabetes related amputations by 44%. Establishment of accredited Diabetes Self-Management Education Programs in 2 health systems 	<ul style="list-style-type: none"> In 2007, MUSC and the REACH partner coalition was awarded CDC funding to establish one of 18 national Centers of Excellence in the Elimination of Disparities (CEEDs) to expand these efforts over the next five years Community sustainability without grant funding is challenging For other challenges, see: Jenkins C, Myers P, Hedari K, et al. (2011).
Health-e-AME (2000) To develop and test a faith-based lifestyle intervention consisting of physical activity and healthy diet	AME Members 7th Episcopal District AME Church, MUSC and the University of South Carolina (USC)/Advisory Board	DOD (2000–2001) \$345k CDC (2002–2005) \$1.3 million NIH (2006–2011) \$3.4 million	<ul style="list-style-type: none"> Significant increase in use of the health-e-AME website Significant increase in physical activity AME members valued participation 	<ul style="list-style-type: none"> The program reached most of the 520 targeted churches Project website increased use from 1% to over 25% in three years In the third year, the partners were awarded an NIH R01 that focused on a tailored intervention Change in church leadership proved challenging
School-Based Health Centers (SBHC) (2006) Improve academic performance	Students from five Title 1 schools; 95% AA School District and Mental Health Association/Advisory Board	HRSA (2006–2010) \$1.3 million	<ul style="list-style-type: none"> Mean of 56% of students in 5 schools enrolled in the clinic. Significant reduction in aggressive behavior in one elementary school 	<ul style="list-style-type: none"> Project has ended SBHCs are critical to get low income children seen in primary care and in mental/behavioral health services
Hispanic Health Initiative (HHI) (2005) Provide seamless, culturally and linguistically appropriate primary health services for Hispanic families; provide health information and outreach activities; develop	Hispanic families in Charleston County Multiple partners including local FOHCs, Community Health Centers, non profit and public organizations/Advisory Board	HRSA (2005–2010) \$1.4 million 2006–present: Funding from National Library of Medicine, Foundations (avg \$150k–350k per year)	<ul style="list-style-type: none"> Policy change at academic medical center to establish language access consistent with CLAS standards Provided education on best practices related to interpreting for Community Health Center (CHC) (9 sites) 	<ul style="list-style-type: none"> Established that video interpreting is consistent with high patient and provider satisfaction Challenges remain with busy practitioners not wanting to wait for interpreters Annual update on best

Project Name/Date Initiated/ Major Goals	Population of Interest/ Community Partners/ Advisory Board or Coalition	Funding	Impact and Outcomes	Current Status and Challenges
cultural competence in the nursing workforce			<ul style="list-style-type: none"> Increased Access to Primary Care at CHC Established a family literacy program (Abrazos). All mothers showed gains on state approved literacy exam Developed reproductive health curriculum for promotoras (Portales de Salud) Initiated Teen Health Leadership Project PASOs—Perinatal outreach program 	<ul style="list-style-type: none"> interpreting practices provided to CHC—9 sites Evolving trust and continued access Abrazos expanded to 2 classrooms with Title one funds to sustain program Curriculum is being manualized All 24 participants (first 2 years) have been accepted into college In year 1, provided prenatal education to 46 families and referral assistance to 63 clients
SISTER to SISTER: Women Helping Women to Quit Smoking (2001) To develop, implement and evaluate a multilevel smoking cessation intervention in partnership with public housing neighborhoods	AA female smokers in public housing neighborhoods Local Housing authorities and residents/ Advisory Board	NHLBI (2008–present): \$3.4 million From 2001–2007, Funding from NINR, ACS, others (avg = \$10K–\$150K per year)	<ul style="list-style-type: none"> Using CBPR approach, developed culturally relevant and community preferred intervention Cessation rates higher in intervention neighborhoods vs. control (39% vs. 11%) in pilot study 	<ul style="list-style-type: none"> In year 3 of implementation of randomized controlled trial in 16 neighborhoods in two states New grant submitted for weight loss intervention See Andrews, Tingen, Jarriel, et al. (2012)
Promoting health and community participation after spinal cord injury (SCI) (2007) To decrease health complications and increase community participation after SCI	Individuals with spinal cord injury disAbility Resource Center (Center for Independent Living); South Carolina Spinal Cord Injury Association/ Advisory Board	NIH (2010–present) \$548k From 2007–present, funding received from AHRQ, Foundations (avg = \$10K–\$50K per year)	<ul style="list-style-type: none"> State level policy change re accessible parking for people with disabilities Data used to inform Peer Navigator intervention development In progress: goal to decrease secondary conditions (i.e. pressure ulcer and urinary tract infections) and rehospitalization, and increase community participation after SCI 	<ul style="list-style-type: none"> Development of the SCI Peer Navigator training curriculum and protocol Awareness of unique needs of people with disabilities is important to maximize participation in the partnership
Impact of the built environment on healthy eating and active living (July 2010) Create and sustain a “movement” for healthy eating and active living; To increase availability and	Residents of North Charleston City of North Charleston Charleston County School District DHEC, Region 7 Low Country Model Communities Trident United Way/	DOD \$216,000 (2010–present)	<ul style="list-style-type: none"> Developed Transportation guides to sources of fresh produce for distribution in target neighborhoods Distribution of 3 Mini Grants to community organizations promote Healthy Eating Active Living in the target 	<ul style="list-style-type: none"> Completion of year one. Community Received CDC Achieve Grant

Project Name/Date Initiated/Major Goals	Population of Interest/Community Partners/Advisory Board or Coalition	Funding	Impact and Outcomes	Current Status and Challenges
accessibility to healthy foods; To create an environment that supports physical activity and includes supporting walking, biking and Mass transit, targeting routes that connect children and their families to schools, sources of healthy foods and recreation	Community Coalition		community of North Charleston	
<p>AA = African American</p> <p>ACS = American Cancer Society</p> <p>AME = African Methodist Episcopal</p> <p>DM = Diabetes Mellitus</p> <p>NIH = National Institutes of Health</p> <p>DOD = Department of Defense</p> <p>FQHC = Federally Qualified Health Center</p> <p>HRSA = Health Resources and Services Administration</p> <p>Sources: Jenkins C, Myers R Heidari K, et al. Efforts to decrease diabetes-related amputations in African Americans by the racial and ethnic approaches to community health, Charleston and Georgetown Diabetes Coalition. <i>Fam Community Health</i>. 2011;34(S1):S63–S78.</p> <p>Andrews J, Tingen M, Jarriel S, et al. Application of a CBPR framework to inform a multi-level tobacco cessation intervention in public housing neighborhoods. <i>Am J Community Psychol</i>. 2012;50(1–2):129–40.</p>				

Box 2**CCHP Advisory Boards****Community Advisory Board (CAB)****25 Members Representing:**

- Partnership Core Director
- Administration Core Director
- CAB Co-Director (faculty)
- Community representatives from the following:
 - Health and Social Services
 - Physical Environment
 - Recreation
 - Education
 - Safety and Transportation
 - Politics and Government
 - Communication/Media
 - Economic
 - Faith Based Organizations
 - Service Organizations
 - Legal Services

Functions:

- Identify community priorities, needs, and interests
- Set research priorities
- Participate and provide input and/or resources for active or potential research such as navigation, access, development, implementation, and evaluation
- Identify community members to participate on project steering committees
- Promote community support for and involvement with research
- Meets quarterly

Scientific Advisory Board (SAB)**15 Members Representing:**

- Research Core Director
- Administration Core Director
- CCHP Project Director
- 2 CTSA Community Engagement Researchers
- Inter-professional researchers from all of MUSC 6 Colleges (Dentistry, Pharmacy, Medicine, Health Professions, Graduate Studies, Nursing)
- Other Inter-professional faculty (librarian, statistician, provost office)
- 2 Community members
- Guide the research mission of the CCHP

Functions:

- Monitor scientific rigor and merit
- Ensure cultural competence
- Provide review for pilot grants
- Review research progress
- Provide advice on resources and leveraging of funding
- Meets semi-annually

Box 3**CCHP Core Responsibilities****Administrative**

- Coordinate and oversee all activities and functions, including fiscal management
- Plan for growth and sustainability
- Establish website and communication systems
- Develop and execute evaluation plan

Research

- Expand resources, support, and infrastructure for community engaged research
- Facilitate integration of CBPR principles and best practices across all projects
- Advance the science of community engagement, through the study of implementation of CBPR

Mentoring

- Facilitate the acquisition of CBPR theory, research methods, and best practices for investigators
- Create opportunities for bi-directional mentorship of academic and community partners
- Establish information exchange networks for mentees/mentors

Partnership

- Collect and maintain inventory of academic-community partnerships
- Serve as resource and coordinating link for potential and existing partners that demonstrate mutual exchange
- Stimulate innovative and sustainable academic-community partnership models

Dissemination

- Promote a systems level infrastructure for dissemination of community engaged products and processes
- Develop best practices and models for dissemination in diverse community settings

Figure 1.
CCHP from an ecologic perspective.

Figure 2.
Center for Community Health Partnerships.