Partnering for Health: Collaborative Leadership Between a Community Health Center and the YWCA Central Massachusetts

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Background: A collaborative partnership among community-based organizations (CBOs)—a community-health center, a YWCA, and 2 academic health centers—developed and implemented open access to physical activity for health center patients. **Objective:** To describe partnership approach taken by 2 CBOs; determine staffs' views of this unique partnership, highlight aspects of the partnership that contributed to its success, identify challenges and mechanisms for overcoming them, and note lessons learned. Assess health center patients' use of YWCA facility. **Methods:** Usage data were obtained from YWCA records. Staff were interviewed using primarily open-ended questions. Inductive approach was used to analyze qualitative data. **Results:** The approach to partnership was largely organic, without formal working documents; nevertheless, the partnership reflected the organizations' missions. Over 4 years, 1134 health center patients made more than 23 000 visits to the YWCA. Responses of health center staff and provider interviewees about partnership processes sorted into the following categories: partnership description and results, partnership benefits, challenges, lessons learned, and advice to other CBOs. YWCA staff interviewee responses reflected the categories: staffing, clientele, and public face. Comments also included challenges, lessons learned, and advice to other YWCAs. **Conclusions:** This partnership achieved notable successes largely because (*a*) it formed to serve a specific purpose that met both agencies' goals, (*b*) leaders made sustained commitments, and (*c*) it managed conflict. The partnership has taken on new projects over time; new ideas for improving access and service to underserved patients continue to emerge. Interorganizational trust and allegiance have been key to addressing challenges; nevertheless, the organic nature of the partnership's origins and the challenges of success have meant that the partnership has restructured its agreement and, to avoid being overwhelmed, limited new patient use.

KEY WORDS: community health partnerships, community health research, health promotion, qualitative research, urban health, vulnerable populations

Community-academic partnerships often form to advance health promotion and disease prevention initiatives.[1–5] Partnerships agree "to share resources, coordinate activities, address common issues, [may] merge their resource bases to create a new entity,"[6] and can assist providers in implementing self-management strategies within the chronic care model, the recommended approach to improving care for people with chronic diseases.[7] Recently, funders' and activists' focus on community-based participatory research has promoted partnerships as the basis of transformational learning and social change.[8–11] One organization, Community-Campus Partnerships for Health (www.ccph.info), established expressly for the

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purpose of fostering such partnerships, has developed and promulgated a set of principles useful for guiding the emergence of partnerships among organizations (www.ccph.info). These organizational partnerships, which seek to "strengthen the relationships between existing organizations,"[12] are viewed as a strategy for engaging communities and providing solutions to health problems.

Establishing and nurturing partnerships between community-based organizations (CBOs) and academic institutions[13,14] has received more attention than partnerships between community-based organizations. Occasionally, these CBO partnerships expand to include academic representation. Examination of the initiation and maturation of health-promoting collaborations between CBOs and academic partners can be instructive for other multi-organization community-based partnerships and for potential academic partners. In 2004, leaders and staff from 2 CBOs, (a federally qualified community health center [CHC] and a local YWCA) initiated a partnership that later expanded to include faculty members from 2 local health professions training schools. The aim of the partnership has been to promote health among a low-income population by allowing CHC patients to use the YWCA for physical activity at no charge to the patient. This article: (*a*) describes the partnership, highlighting process and outcome elements; (*b*) identifies challenges, and (*c*) specifies lessons learned.

Background

Several factors served as catalysts for the health center and YWCA to develop an exercise program for underserved patients. These included: (1) the health center's growing group visit program for patients with diabetes that emphasized recommendations for physical activity, (2) an increased awareness among health center providers of the chronic disease model with its specific inclusion of community resources,[7] and (3) increasing frustration among health care providers regarding their patients' lack of options to engage in physical activity. At the same time, the local YWCA was working to diversify its staff, meet its mission, and strengthen ties to other organizations.

Shortly after the health center and the YWCA agreed to a formal contract for institutional memberships to serve patients, a local college of pharmacy faculty member, already engaged with the group visit program, began a grant-funded research project to evaluate the relationships between diabetes control, fitness level, exercise uptake, and medication adherence. He joined the physician champion and the director of fitness at the YWCA together with the fourth core partnership member—a local medical school faculty member who joined in 2006—to form the "core group." The latter's role evolved to include ensuring adequate inter-agency communication, developing data analysis plans, providing expertise with narratives and qualitative research, identifying and working with student research assistants, and spearheading interactions with the university's institutional review board. A description of the partnering organizations and specific information about the patient/YWCA referral process have been published previously.[15]

Methods

Members of the core implementation/evaluation group recognized the value in understanding how leaders and staff at the 2 CBOs had viewed this 4-year 2004-2008 partnership and withstood the challenges of providing open access for health center patients. Consequently, they developed a plan to conduct guided interviews with selected leaders and staff at both CBOs. They constructed a 12-question open-ended interview form and modified it (Figure 1) on the basis of the recommendations of the administrative leaders of both CBOs. Institutional review board approval was obtained from the medical school and research permission from the CHC board.

To develop a list of CBO interviewees, the core group elected to have the YWCA member identify the agency's staff members who had been involved with the physical activity partnership (n = 9). Similarly, the health center's physician champion identified physicians, nurse practitioners, medical assistants, administrators, and social work staff who had participated in referring patients, developing partnership agreements, or analyzing usage data (n = 19). The medical school faculty member trained 3 medical students to conduct the interviews. They contacted potential interviewees by e-mail and arranged interviews in person or by telephone. One student knew shorthand and was able to transcribe all of the YWCA and 5 of the CHC interviews verbatim. Other interviews were captured through thorough note taking, with notes read back to the interviewee for affirmation or correction at the close of the interview.

The interview instrument included questions about the participant's roles and responsibilities and length of employment at the site. Open-ended questions related to core constructs: the organization's mission and fit with the open access to exercise program, benefits of the organizations working together, factors that contributed to making the partnership successful, changes the site and/or respondent had experienced as a result of the partnership, challenges that developed

FIGURE 1 ● Interview Guides

YWCA Staff Interview Guide

Name_____ Position_____ Date_____

Thank you for agreeing to take about half an hour to talk with me about your work here at the YWCA and about the effect of the partnership between the YW and Family Health Center of Worcester. I have a series of prepared questions that I'd like to ask you.

1. How long have you been working at the YWCA?
2. In what capacity have you worked at the YW? *(Probe for whether the respondent's position has changed over time and if it has, how.)*

I think you know that in the spring of 2004, the Family Health Center of Worcester purchased several institutional memberships so that patients from the health center could exercise at this facility. I'm interested in whether you have observed changes in the YW as a result of this partnership and if so, what those changes have been and how you view them.

1. First, however, could you tell me whether (and if so, how) you see the mission of the YW and the exercise initiative linking with one another?

2. What changes have you observed in:
   a. The YW's clients? *(Probe for numbers overall—a sense of being busier, change in demographics, in clients' knowing about exercise)*
   b. The staff's acceptance and attitudes towards users who are patients of the health center? Have they had to adapt? How?
   c. How prior users of the YW are (or are not) interacting with and adjusting to the new health center's users? Has this been an issue? Why/Why not?
   d. The exercise classes: their availability and their use by clients?

3. Have you had to make any adjustments in the approach you take to your work at the YW as a result of the health centers patients using the facility? *(Probe for what those changes have been and why they've been made.)*

4. How would you describe this partnership between the YW and the health center? *(Probe for whether interviewee views it overall as positive or not and why.)*

5. Would you recommend this type of organizational partnership to other community YWs and health centers?

6. What do you think has been the most positive result of the partnership between the YW and the health center?

7. What has presented the most difficult challenge in this relationship?

8. Do you feel as if you have had to change personally as a result of these changes in the YW?

Thank you very much.

FHCW Interview Guide

Name_____ Position_____ Date_____

Thank you for agreeing to take time to talk with me about your work at FHCW and about the your experience with the partnership between the health center and the YWCA and YMCA. I have a series of prepared questions that I'd like to ask you. The initial questions refer to the partnership with the YWCA. Then I'd like to ask you a few questions about the partnering experience with the YMCA. First,

3. About how long have you been working at the FHCW?
4. In what capacity have you worked at the FHCW?

I think you know that in the spring of 2004, the Family Health Center of Worcester purchased several institutional memberships so that patients from the health center could exercise at the YWCA. I'm interested in how you think this partnership has affected the health center's ability to provide services for its patients and what the challenges of this partnership have been.

1. First, could you tell me whether (and if so, how) you see the mission of FHCW and the exercise initiative with the YWCA linking with one another?

2. As a result of this partnership, what changes have you observed in the health center's ability to provide services:
   a. to its patients?
   b. to its staff?

3. Have you (or others at the health center that you know of) made adjustments in the approach you take to helping patients improve their health as a result of the partnership with the YWCA? *(Probe for what those changes have been and why they've been made.)*

4. How would you describe this partnership between the YW and the health center? *(Probe for whether interviewee views it overall as positive or not and why.)*

5. Would you recommend this type of organizational partnership to other health centers and YWs?

6. What do you think has been the most positive result of the partnership between the health center and the YWCA?

7. What has presented the most difficult challenge in this relationship?

8. You probably know that the health center purchased a membership for employees in addition to the memberships for patients. As a health center staff member, have you used the institutional membership to the YWCA to work out? If yes, could you briefly describe your experience? I'm interested in:
   a. whether you used the YWCA prior to the health center offering it as a benefit
   b. how frequently you use the facility
   c. what you use it for
   d. whether your experiences have—on balance—been positive (why/why not).

9. How has this program with the YWCA changed your job/tasks/daily work, if at all?

Finally,
What lessons have you drawn from the experience FHCW has had partnering with the YWCA? What advice would you give to other organizations that might be contemplating entering into a similar partnership?

Thank you very much.

as the partnership matured, and lessons learned that might inform plans and activities of other institutions considering this type of partnership.

Interviewers typed results of each interview. Responses were consolidated and then analyzed using a general inductive approach.[16] To analyze text responses to open-ended questions about experiences and perceptions, data were categorized using content analysis techniques.[17] This method uses a set of coding procedures for making replicable inferences from data to their context and identifies themes or categories. After repeated readings of the participants' responses, 1 of the investigators developed a coding scheme on the basis of the interview questions and responses. Two authors (S.B.C. and P.F.) independently reviewed transcripts to confirm that the codes were comprehensive and reproducible. Responses were reviewed and agreement reached. Subsequently, emergent themes were identified and exemplar quotes selected. Descriptive statistics were used to characterize the study sample.

To describe patients using the YWCA, we collected patient age, sex, and ethnicity from YWCA registration data. We used Microsoft Excel and MS Access (Microsoft Corporation, Redmond, WA) relational databases to catalog YWCA visits.

● Results

Outcomes: usage and the challenge of success

Referrals from the CHC to the YWCA gradually increased as word spread among patients about the program and as providers received positive feedback from patients about their experiences. During the 48-month study period, a total of 1134 patients aged 18 years or more made at least 1 visit to the YWCA,

for a total of 23 631 visits. The median number of visits was 4; the range was 1 to 601. With an age range of 18 to 80 years, the average age of patients who made at least 1 YWCA visit was 38.7 years (SD = 12.89). The proportion of women using the YWCA reflected the percentage of women in the health center adult population (64.8% vs 61.1%, respectively). The proportion of Latino or black patients exercising, however, was notably higher than the percentage of blacks and Latinos among health center adults (69.0% vs 56.9% respectively). Otherwise, exercisers were similar to the CHC patient population.

As the program ended its second year of operation, the number of new referrals reached a peak, with providers referring approximately 200 new patients per month to the YWCA; at this point, health center patients were accounting for 600 to 800 visits monthly which, at a high of 10% of the visits, represented a significant proportion of overall YWCA usage. At 24 months, usage data showed that CHC patients had made close to 3000 visits during the previous quarter. At this point, YWCA staff and leadership felt that they needed to change the partnership's parameters because so many health center patients were using the YWCA's modest exercise facility. Overcrowding meant that occasionally members were finding it difficult to get access to the equipment. The changes that the YWCA instituted were to reduce the number of patients who could use the facility simultaneously from 12 to 6 and to suspend acceptance of new referrals. While health center leaders, providers, and board members understood the reason behind this action, they were disappointed and concerned that this successful program was being curtailed; they worried that patients could feel insulted or betrayed just as trust was being established.

By this time, the core group found that their intermittent meetings had become essential to ensuring that the partnership would survive the stresses of success. The partners renewed their focus on keeping avenues of communication open and on ensuring that all parties understood the reasons for the newly imposed limits. Simultaneously, the group reinvigorated its efforts to identify other local fitness organizations that would be willing to provide similar open access to low-income patients.

Interview results

Each of the 9 YWCA staff members and 18 of the 19 health center staff/providers agreed to be interviewed. Respondents were almost exclusively female, had worked at their host agency for an average of 9 years, and held positions including manager/administrator, direct service provider/clinician, and instructor.

All interviewees answered questions about their organization's mission and the partnership. Overall, respondents viewed the partnership as a natural outgrowth of their mutual and complementary missions, as well as an avenue for achieving those missions. Words interviewees used to describe the connection between their organization's mission and the partnership included "in sync," "a perfect match," "... both interested in working with multicultural populations," "missions are the same." One health center clinician captured the connection between the 2 organizations as: "... filling the space between medical problems and what is needed to improve health."

Community health center

Responses about the partnership sorted into the following categories: partnership description and results; benefits/positive aspects, challenges; lessons learned; and advice to other CBOs (Table 1). Respondents described the partnership in words that reflected implications for patient care as well as for the health of the community more broadly. One provider noted that the partnership not only expanded the array of services the health center could provide to its current patients, but it likely attracted some new patients. Several subcategories developed from the category, "Benefits/Positive Aspects of Partnership." These include: integration of physical activity discussions into the patient visit, a cultural shift in how physical activity is viewed, expanded opportunities through systems change, and broader implications reflecting the ability to contribute positively to the city's health. Providers linked the ability of patients to take positive action to improve their health with personal empowerment.

The category termed, "Challenges" consists of 4 subcategories. These include: communication, setting priorities, follow through, and success. The main *communication* challenge was inadequate feedback about patients' use of the YWCA. Interviewees recognized the difficulty of obtaining these data on individual patients, given the lack of staff dedicated to the project. Nevertheless, they felt that without regular feedback, they could not respond adequately to patients' successes or difficulties in maintaining physical activity. *Setting priorities* referred to the health center's difficulty—once access was restricted because of the problems of success—in trying to set priorities on which patients should be referred. The challenge of *patient follow-through* referred to patients attending an orientation to the YWCA, but going only once or twice. Nevertheless, with the high numbers of patients using the facility, the issue of *success* became an additional challenge. "Lessons Learned" reflected providers' and staff members' understanding that this type of partnership is possible and beneficial.

TABLE 1 ● Community Health Center Respondents' Comments by Category

Category/Theme	Definition	Quote
Partnership description/results	Implications for patient and overall community health	"It allowed the opportunity for access to exercise equipment.""It attracts patients to the health center; adds value for current patients; demonstrates commitment to patients . . . "
Benefits/positive aspects of partnership		
Addressing needs through physical activity as part of the patient visit	Adjustments providers have made in their approach, increasing attention to physical activity as a way to help patients improve their health	" . . . able now to do more than simply counsel patients" " . . . having something to offer pushes me to talk about it [exercise] with stronger emphasis." "I have health maintenance conversations with patients now." " . . . helps take a more holistic approach . . . offers a solution." "Patients ask for it; they enjoy it" " . . . [it] has made the conversation easier by being able to offer memberships at no charge"
Cultural shift	Perspective related to importance of physical activity	"The program has helped to make this shift possible." "Number of visits indicates empowerment. They can improve their own health through their interactions."
Opportunities/system change	Type of expanded opportunity the partnership offers	" . . . the actual advantage it gives to patients. They would have no chance/opportunity otherwise. Often the patients do not know how to initiate a process in a system—so the most positive aspect is the patient opportunity."
Broader implications	Contributing to improving health of the local community	"Building healthy community. Health resource in the community. Social determinants of health are greater than just a diagnosis. Two agencies contributing to health of the city."
Challenges		
Communication	Feedback to staff	" . . . suggest putting energy into making feedback a regular feature . . . It would give us a heads-up to know the statistics." "Need ongoing communication with providers . . . .gives us energy to keep going."
Setting priorities	With limited space, determining which patients should have priority	"A lot of patients are requesting to go. Sometimes they are patients who don't really need to go."
Patient follow through	Extent to which referral for physical activity results in patient use	" . . . they do up front work on patients. Then patients don't come back . . . the investment doesn't appear to pay off."
Success	Program's success meant it had to be restructured	"It has been the issue of access. . . . how do you manage it?"
Lessons learned	Major insights from the experience of this partnership	"I was getting cynical because patients weren't making a change. Now I see they will. I was surprised to be surprised." "Collaboration is possible and can be implemented successfully."
Advice to others	Recommendations regarding whether to develop this type of partnership	"Do it and do it better!" " . . . it is really important that health centers are outside the walls of delivering care . . . " "We didn't plan for overwhelming positive response . . . Wish we had done more prep."

YWCA Central Massachusetts

Staff comments regarding the partnership process fell into 3 categories: staffing, clientele, and public image (Table 2). The effect on staffing was considerable; administrative leaders explained that 3 or 4 of the 15 strength and cardiovascular staff elected to leave the YWCA because they preferred not to work with low-income health center patients. Their departure was balanced by existing and newly hired staff who valued the partnership ideals of serving a more ethnically diverse population. The effect on traditional YWCA clientele of patients using the facility had positive and negative effects. According to staff, some members seemed to have gained a broader understanding of the agency's mission and enjoyed the greater diversity of users. A

TABLE 2 ● YWCA Respondents' Comments by Category

Category/Theme	Definition	Quote
Staff	Effect on staff and staffing	"[It] changed my belief systems and feelings about why I am here. I want to do some good . . . maybe we can do some here." "Some staff moved on. They didn't want to change their opinion of who should use the facility. People were outside of their comfort zone because they weren't working on fit or healthy people."
Clientele	User characteristics and change in mix	"A number of members left to find fitness elsewhere. It's hard to say exactly why they left . . . It gave us a chance to talk to members every time there was dissatisfaction and talk about our mission." "What I noticed was growth and changes in clients we were serving as they merged in with the YWCA. I attribute that to them feeling that they were being valued because they had a way to access a facility like this . . . "
Public image	Reinforce mission to the public	"Getting a critical mass of diverse users shows who the YW wants to serve." "This helps us reach into the community and create communities."
Challenges		
Communication	Ongoing information to and from staffInformation sharing with health center providers	"We started institutional membership without giving staff information." "The paperwork would go back and forth . . . it was frustrating and upsetting for the patients and ourselves."
Logistics	Adequate space, staff	" . . . it was so overwhelmingly crowded."
Clientele	De-conditioned, inadequately informed potential users	"It's been prescription medicine. Patients come to orientation and don't return."
Lessons learned		
Staffing	Staff need to have a part in developing and understanding the program	"Work with staff to help them adapt."
Leadership	Role and importance of leadership for implementing an open access program	"Key is to have people in charge of the facility ready and open and willing to change the way they do things."
Clientele	How to introduce de-conditioned, low-income individuals to physical activity	"Tailor orientation to the population."
Patience	Take time to work out problems	"It may take a few years to get to where we want to be."
Advice to others	Recommendations regarding whether to develop this type of partnership	"Definitely! It's wonderful." "Absolutely! Exercise is for everyone . . . " "Have one person in charge of following up with clients."

small number of other members, however, opted to leave the YWCA rather than continue their membership in the more diverse environment. While organization leaders initially tried to educate and retain these members, ultimately they were willing to lose them. YWCA leaders noted that the partnership had given them "bragging rights" and burnished their public image.

Challenges the YWCA interviewees noted were similar to those that the health center staff enumerated. These include: communication, particularly to staff regarding the program; logistics, as high patient usage stressed the YWCA's limited facilities; and clientele, primarily related to patient follow through on recommended physical activity.

Lessons learned

Insights gained from the experiences of this partnership were numerous. Community health center administrative interviewees reportedly learned that 1 person can make a difference, that successful collaboration is possible among unlikely partners, and that, in the words of 1 respondent, the "bridging people" are key factors for success. Lessons from the clinicians' point of view included that large community organizations can collaborate successfully and that patients will engage in physical activity if reasonable resources are available. For the YWCA, lessons culled from the interviews fell into 4 categories: the need for training and diversity of *staff* as well as for having a single person responsible for the program; affirmation of the importance of high level administrative *leadership* solving problems and not walking away from a partnership; making sure the facility and programs offered meet *client needs*; and finally, the requirement for *patience*—all need to view such a partnership as a long term relationship requiring attention to issues as they develop; a partnership does not run in the usual 3- to 5-year cycles.

Advice to others

Community health center as well as YWCA interviewees unanimously agreed that they would recommend this type of organizational partnership to other agencies. They counseled making sure, however, that budgetary implications and capacity and communication issues be addressed in the initial stages. Other recommendations included that: (*a*) communication between agencies and among staff be regular and frequent, (*b*) patients understand why they have been referred to the YWCA and go through a full orientation before gaining open use privileges, (*c*) a designated staff person follow-up with patients who attend YWCA only once, and (*d*) staff be available to guide deconditioned patients. Health center respondents added that: (*a*) organizations developing this type of partnership should roll the program out slowly, (*b*) the social part of physical activity be emphasized, (*c*) providers receive regular data on their patients' usage, and (*d*) staff be trained to make patients feel comfortable and welcome.

Discussion

Policy analysts have noted the lack of connectivity in our health care system and the resulting challenges to achieving common goals and establishing reinforcing linkages.[3] The ability to "establish missing but critical connections" underlies the power of collaboration and partnering.[3,18,19] Researchers[20] have suggested that due in part to the fact that no 1 group has all the resources needed to bring about positive change in community health, partnerships are necessary for disease prevention and health promotion. In addition, partnerships help foster community awareness, promote an ecological approach to health, and contribute to implementing the Chronic Care Model.

As viewed by CBO and CHC staff and administrators, the partnership reported on in this article demonstrates how organizations sharing broad health improvement and social justice goals can work collaboratively to expand physical activity opportunities for low-income, de-conditioned patients. Successful organizational linkages do not come, however, without strong leadership as well as care and attention paid to the needs of the partnering agencies. In the case reported here, while staff and administrators viewed the partnership as successful, they generally agreed that there had been insufficient in-depth planning and anticipation of the challenge of integrating a large number of inexperienced users into the YWCA's usual operation. More careful planning—for instance, by considering detailed and explicit principles of partnership at the start (www.ccph.info)—might have helped avoid some of the challenges of success. In hindsight, although many partnership principles were addressed implicitly, failing to have established at the outset explicit processes for decision making and conflict resolution proved to have been a significant oversight. The organic development of the partnership meant that challenges were addressed as they arose, without the benefit of a clearly defined process. Thus, staff felt that they were faced with intermittent brush fires; provider uncertainty and patient confusion about YWCA access were likely additional unintended outcomes of referral arrangement changes. Nevertheless, strong leadership and commitment to the partnership ensured overall success.

Study participants affirmed the critical importance of leadership commitment and mission to the partnership's success, particularly the commitment to persevere when challenges arose. In a recent case study[21] of a capacity building initiative aimed at building an interorganizational network comprising several CBOs, a research university, media, and foundations, the authors concluded that leadership was 1 of several factors contributing to building effective organizational capacity. Organizations that form successful partnerships have been found to be characterized by strong, transformative leaders.[22–25] These leaders have the vision and skills required to motivate individuals and organizations to become a collective force for change.[21] This type of leadership characterized the partnership described in this study. At the point when the YWCA began to hear member complaints about crowding, saw a small number of staff electing to leave their jobs, and found that several full-pay members let their memberships lapse, the organization's leaders might have chosen to end the partnership. They did not, however. Rather than let these challenges overwhelm the partnership, the YWCA leaders suggested modifying the agreement by limiting patient use and halting new referrals. While health center leaders were apprehensive that patients would see these new limitations as shutting the door on a welcome opportunity, they understood the need for this change. Simply ending new patient referrals for exercise, however, did not seem like an acceptable option. Fortunately, CHC leaders had been exploring additional partnership opportunities for patient physical activity and at about this time were able to offer other options to patients.

Community health center providers noted that the YWCA partnership offered them a new way to address their patients' needs for physical activity. They were particularly pleased that they were able to do more than simply advise patients to engage in physical activity; they now could encourage patients to use a facility that was open and available to them. This type of agency partnering was included in

recommendations made by Improving Chronic Illness Care and its team of experts. In 2003, they updated the chronic care model to reflect advances in the field of chronic care. One of their recommendations, that is, to include community policies, came under the model's original rubric of community resource mobilization. More specifically, they expanded the model by including the recommendation that care sites "form partnerships with community organizations to support and develop interventions that fill gaps in needed services" (www.improvingchroniccare.org [last accessed February 23, 2011]). The team commented that this type of partnering would help health care sites look outside themselves to improve patient care and avoid duplication. The partnership presented and described in this study reflects that recommendation and demonstrates the benefit to providers, patients, and organizations.

Leaders from the 2 CBOs that formed the initial core of this partnership welcomed the gradual involvement of the academic representatives with their objective viewpoint and expertise in evaluation. The presence of the academic partners—individuals committed to ensuring a positive working relationship between the 2 CBOs—helped keep lines of communication open. In hindsight, the periodic—every 1 to 2 months—meetings of the core group appear to have been a linchpin in sustaining the partnership. Through regular meetings, the core group developed a cohesive identity and manifested their commitment to the partnership through reviewing and monitoring the initiative's progress and making adjustments as needed.

Limitations

This study has several limitations. First, although participants were assured that their responses would be confidential, they may have been concerned that their comments would be made available to the physician leader or organization administrator. Second, given that the partnership developed from a strong, multiyear, and ongoing connection between the health center's physician leader and YWCA administrators and staff, the ability for other organizations without this long history to develop a similar partnership may be more challenging than interviewees acknowledged. Third, while interviews were captured verbatim using shorthand or were read back to interviewees to ensure accuracy, they were not tape-recorded and thus may not have captured every statement. Balancing this limitation is the positive aspect of interviewees not feeling the inhibition that can accompany tape-recorded interviews.

Long-term outcomes after completion of study

Three years after new patient referrals were suspended, CHC patients continued to use the YWCA at a steady rate of about 200 to 250 visits per month. To reenergize the program, the YWCA leadership has asked the health center—through the core group mechanism—to refer a limited stream of about 10 new patients per month. Now, however, the YWCA has appointed a bilingual staff member to receive all referrals; she orients patients individually, explores their physical activity history and interests, and helps them develop an initial exercise regimen. This new approach responds to some of the challenges raised in the interviews.

Likewise, the core group has built on its working relationship to develop additional initiatives. These include: a recent state-based foundation's 3-year grant to the YWCA to reduce/eliminate disparities in overweight and obesity among the city's Latino population, an internal medical school activation grant for mentored exercise at the YWCA for a small group of Latino patients with uncontrolled diabetes, funding for 2 summer project research assistants through the medical school's summer research program, several pharmacy school service-learning students placements at the YWCA, an academic scholarship for medication adherence review, and incorporation of an Albert Schweitzer fellow whose project reached out to and supported patients trying to integrate physical activity into their weekly routine.

Conclusion

This partnership achieved notable successes largely because it was formed to serve a specific purpose that met the goals of both agencies and because strong, transformational leaders made a sustained commitment to it. In addition, the partnership has taken on new projects over time; new ideas for improving access and service to underserved patients continue to emerge from staff as well as patients. Interorganizational trust and allegiance have been key to addressing challenges; nevertheless, the organic nature of the partnership's origins and the problems of success meant that the partnership had to restructure its initial agreement. As the nation continues to try to meet the challenges of the epidemic of overweight and obesity, organizations trying to provide avenues for low-income individuals to engage in physical activity may benefit by partnering with a fitness organization. Through developing partnership arrangements, they may be able to offer opportunities for physical activity for their client or patient population. Lessons learned from the experiences chronicled in this article can provide guidance for developing and nurturing such a partnership.

REFERENCES

1. Carney JK, Hackett R. Community-academic partnerships: a "community-first" model to teach public health. *Educ Health (Abingdon)*. 2008;21(1):166.
2. Griffith DM, Allen JO, DeLoney EH, et al. Community-based organizational capacity building as a strategy to reduce racial health disparities. *J Prim Prev*. 2010;31(1-2): 31-39.
3. Lasker RD, Weiss ES, Miller R. Promoting collaborations that improve health. *Educ Health (Abingdon)*. 2001;14(2): 163-172.
4. Uyeda K, Bogard LM, Hawes-Dawson J, Schuster MA. Development and implementation of a school-based obesity prevention intervention: lessons learned from community-based participatory research. *Prog Community Health Partnersh*. 2009;3(3):249-255.
5. Wolff M, Maurana CA. Building effective community-academic partnerships to improve health: a qualitative study of perspectives from communities. *Acad Med*. 2001;76(2):166-172.
6. Butterfoss FD. Models of collaboration. In: *Coalitions and Partnerships in Community Health*. San Francisco, CA: Jossey-Bass; 2007:30.
7. Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? *Eff Clin Pract*. 1998;1(1):2-4.
8. Minkler M, Wallerstein N, eds. *Community-Based Participatory Research for Health: From Process to Outcomes*. San Francisco, CA: Jossey-Bass; 2008.
9. Seifer SD, Gottlieb B. Transformation through partnerships. *Prog Community Health Partnersh*. 2010;4(1):1-3.
10. Seifer SD, Sgambelluri A. Mobilizing partnerships for social change. *Prog Community Health Partnersh*. 2008;2(2):81-82.
11. Wallerstein N, Duran B, Minkler FK, Foley K. Developing and maintaining partnerships with communities.In: Israel BA, Eng E, Schulz AJ, Parker EA, eds. *Methods in Community-Based Participatory Research for Health.* San Francisco, CA: Jossey-Bass; 2003.
12. Crisp BR, Swerissen H, Duckett SJ. Four approaches to capacity building in health: consequences for measurement and accountability. *Health Promot Int*. 2000;15(2):99-107.
13. Community-Campus Partnerships for Health. *Achieving the Promise of Authentic Community-Higher Education Partnerships: Community Partners Speak Out!* Seattle, WA: Community-Campus Partnerships for Health; 2007.
14. Harkavy I. From the rhetorically engaged to the truly engaged campus: some approaches to consider. In: *Community-Campus Partnerships for Health: Partnership Perspectives*; 2001:101-105.
15. Candib LM, Silva M, Cashman SB, Ellstrom D, Mallett K. Creating open access to exercise for low-income patients through a community collaboration for quality improvement: if you build it, they will come. *J Ambul Care Manage*. 2008;31(2):142-150.
16. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. *Am J Eval*. 2006;27(2):237-246.
17. Pope C, Ziebland S, Mays N. Qualitative research in health care. Analysing qualitative data. *BMJ*. 2000;320:114-116.
18. Butterfoss FD. Why coalitions? In: *Coalitions and Partnerships in Community Health*. 1st ed. San Francisco, CA: Jossey-Bass; 2007:49-60.
19. Wolff T. *The Power of Collaborative Solutions*. 1st ed. San Francisco, CA: Jossey-Bass; 2010.
20. Green L, Daniel M, Novick L. Partnerships and coalitions for community-based research. *Public Health Rep*. 2001;116(suppl 1):20-31.
21. Gilbert KL, Quinn SC, Ford AF, Thomas SB. The urban context: a place to eliminate health disparities and build organizational capacity. *J Prev Interv Community*. 2011;39(1):77-92.
22. Butterfoss FD, Goodman RM, Wandersman A. Community coalitions for prevention and health promotion. *Health Educ Res*. 1993;8(3):315-330.
23. Butterfoss FD, Goodman RM, Wandersman A. Community coalitions for prevention and health promotion: factors predicting satisfaction, participation, and planning. *Health Educ Q*. 1996;23(1):65-79.
24. Goodman RM. A construct for building the capacity of community-based initiatives in racial and ethnic communities: a qualitative cross-case analysis. *J Public Health Manag Pract*. 2009;15(2):E1-E8.
25. Roussos ST, Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. *Annu Rev Public Health*. 2000;21:369-402.