TEAMING UP WITH PUBLIC HEALTH:

The Family Physician Community Collaboration Guide

Introduction

The Family Physician Community Collaboration Guide builds on the American Academy of Family Physician's Teaming Up with Public Health series, which was developed to empower family physicians to better integrate public health efforts into their practices and communities. A family physician's ability to maintain trusting relationships with patients across their lifespan provides a unique perspective on the communities and places where people live, learn, work and play. This clinical insight offers the opportunity to advance community health efforts to address the social and environmental conditions that impact patient health. While clinical care is necessary to promote and maintain health among individuals and families, family physicians often see firsthand the conditions that support healthy people, which are a product of policies, systems and environments.[1]

To address a community's unique health and social needs, family physicians and care teams can build partnerships among organizations that impact community conditions. Creating impactful changes requires collaboration across many sectors in the community, including but not limited to health care, public health, social services, religious organizations, businesses and education stakeholders.[2]

From my many years of family practice, I am convinced that Americans need to live and work in environments where they can practice healthy behaviors and obtain quality medical care…Creating these healthy environments for people of all ages will require their active involvement in grassroots efforts…The most effective collaborations include representation from various sectors — businesses, clinicians, schools, academia, government and the faith-based community.

— REGINA BENJAMIN, M.D., M.B.A., FORMER U.S. SURGEON GENERAL, PRINCIPLES OF COMMUNITY ENGAGEMENT, 2011[3]

Family physicians are encouraged to connect with their local, state or county public health departments, as these connections can fill a gap in resources for health educators, community health workers and outreach services. Successful integration with local public health and community services could free up physician time and practice resources for other aspects of patient-centered care. Additionally, in times of pandemics or disease outbreaks, a strong connection between primary care and public health can aid in effectively disseminating information, guidance, supplies, testing, contact tracing and vaccines. This guide offers practical information for family physicians to identify a starting point for collaborating with communities. Our goal with this guide is to provide a high-level understanding of collaboration as a strategy for integrating public health resources in communities.

Shared Language for Shared Work

Addressing patients' social needs is a shared goal among social services, public health, health care professionals, payers and health systems. Communication across sectors requires shared language. The following definitions are provided to orient family physicians to this evolving landscape.

Social determinants of health (SDoH) are the underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age.[4]

Health inequities result from these SDoH, and their unequal distribution according to social position results in differences in health outcomes among population groups that are avoidable and unjust.

Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles are shaped by social structures linked to discrimination or exclusion.[5]

Health-related social needs result from SDoH and are the unmet social and economic needs that affect an individual's health and well-being. These may include housing instability and quality, food insecurity, education, employment, health insurance status, personal safety, internet access, transportation and essential utilities, such as water and electricity.[6]

Laying the Foundation

Only 16% of health outcomes can be attributed to clinical care, while 34% result from health behaviors and nearly half (47%) are attributed to socioeconomic factors.[7] Family physicians see firsthand the impact of unmet health-related social needs on vulnerable patient populations. They are often at the frontlines of improving community health where they live and practice — a strong motivation for why family physicians entered the medical profession.

Addressing health inequities and disparities within a community is a complex challenge and requires the effort of multiple sectors and stakeholders to create change. Cultivating community relationships and collaborating with public health organizations can better integrate family physicians into community health improvement efforts.

Public health is broadly defined as the "science of protecting and improving the health of people and their communities."[8] National organizations have called for integrating public health and primary care due to the substantial impact of social, economic and environmental issues on health outcomes.[9,10,11] Family medicine and public health share the goal of improving the health of families and the communities they serve.

Public health professionals often refer to the causes of health inequities as "downstream," "midstream" or "upstream."[12] Downstream refers to the individualized intervention and treatment approaches physicians and other clinicians take to address a health need. This often occurs in the clinic or direct care setting for family physicians and may include emergency, surgical or pharmacological interventions. Midstream refers to an individual's modification to address their needs, such as altering personal lifestyle choices to improve health. This occurs inside and outside the clinical setting, with additional support offered by the physician or clinical care team in modifying individual patient behavior, such as physical activity, nutrition or tobacco use. An upstream approach looks at the bigger picture of public health and addresses the social and political factors that impact individuals and communities, often referred to as the SDoH. The upstream framework is useful for evaluating areas for action when planning community-wide and systems-level interventions.

Family physicians are well-positioned to support public health organizations by informing community leaders of all three frameworks: downstream strategies in clinically treating patients; midstream strategies by recommending individual patient behavioral changes; and upstream strategies to change policies, systems and environments.

Camara Jones, M.D., Ph.D., M.P.H., family physician and past president of the American Public Health Association, explains the upstream and downstream dynamic through her 'cliff of good health' analogy in this thoughtful, five-minute video.

AAFP Resources to Help Lay the Foundation

- Policies on Health Equity Issues (AAFP policies)
- Integration of Primary Care and Public Health (AAFP position paper)
- Implicit Bias Resources (AAFP toolkit)
- Social Determinants of Health (AAFP audiobook)
- Health Equity: Leading the Change (AAFP CME)
- Anti-racism: Tools for Change (AAFP CME)
- The EveryONE Project™
- Neighborhood Navigator
- Health Policy Issue Briefs (food insecurity, gender pay gap in medicine, Health in All Policies, health literacy, housing instability, socioeconomic status, transportation)
- The Physician Advocate

Understanding Community Needs

Although family physicians may have different motivations to practice medicine, most practice in the context of caring for families and communities. Understanding and considering the diverse and unique attributes of communities in your care can highlight opportunities to disrupt assumptions and foster trusting relationships. Each community is a mosaic of characteristics and factors that impact a population's shared culture. Shared culture can be defined by group membership, such as ethnic, racial, geographical or linguistic groups, as well as a collection of values, customs, communication styles, social ties, behaviors and beliefs[13] as shown in *Figure 1*. Approaching patient care and community collaboration with humility and consideration for patient values is essential to building trust, improving the quality of care and taking collective action.

Considering that a typical family physician's day-to-day responsibilities are not optimized to gather and synthesize the social information needed to inform their communities' local health and social needs, the AAFP encourages family physicians to rely on partners already capturing this information. A community health assessment or a community health needs assessment is a state, tribal, local or territorial health assessment that identifies health-related social needs and issues through comprehensive and systematic data collection.[14] A CHA or CHNA provides community organizations with data and information about the community's current health status, needs and issues.

Figure 1. Shared Culture Characteristics

Developed from MacQueen KM, McLellan E, Metzger DS, et al. What is community? An evidence-based definition for participatory public health. Am J Public Health. 2001;91(12):1929-1938.

Often, communities will have existing health or well-being coalitions of community members, stakeholders and leaders with a shared goal of improving community health. These groups are often responsible for developing a community health improvement plan, which is a long-term plan to address issues and barriers identified in the CHA or CHNA. These coalitions frequently form in communities with federal, state and non-profit funding and are dedicated to health promotion and public health. *Contact your local, county and/or state health department to determine if your community has a health and well-being coalition and whether a CHA or CHNA is available.*

Table 1. Types of Community Assessments, Plans and Analysis[15,16]

Community Health Needs Assessment	Community Health Assessment	Community Health Improvement Plan	Demographic Analysis
Completed every 3 years by non-profit hospitals	**Completed every 3-5 years by state, tribal, local or territorial health offices**	**Completed every 3-5 years by state, tribal, local or territorial health offices**	**Updated data when census or national survey data is available**
This assessment identifies significant health needs of communities served by hospitals, prioritizes those health needs and identifies resources to address them.	This assessment systematically examines the health status indicators for a given population to identify key problems and assets in a community.	This plan is a long-term, systematic effort to address public health problems based on the results of the CHA activities and the community health improvement process.	This analysis reviews critical geographic and demographic data at the ZIP code level, leveraging a variety of datasets that include the Health Resources and Services Administration's Uniform Data System to support improved access to health care.
These reports must be made publicly available. Learn more about the requirements for charitable hospitals here.	Community engagement and collaborative participation are essential.	In collaboration with community partners, health and other governmental, education and human service agencies use plans to set priorities and coordinate and target resources.	Learn more here and create maps focused on the community using Health Landscape.

Family physicians are encouraged to connect with community health organizations to better understand the challenges, partners, initiatives and progress made in improving community health. When building connections with community partners, shared goals create common ground for discussion and potential interventions. Determine where there is alignment between your family medicine practice and the goals of potential partners and community leaders.

> *Too often, public health, primary care and community development are working in the same neighborhoods, often with the same people, but don't know one another. By joining forces and harnessing each other's strengths and resources, these sectors together can have a more powerful impact on improving population health and addressing long-standing, persistent health inequities.*
>
> — DOUGLAS JUTTE, M.D., M.P.H., THE PRACTICAL PLAYBOOK II[17]

Consider Your Capacity for Collaboration

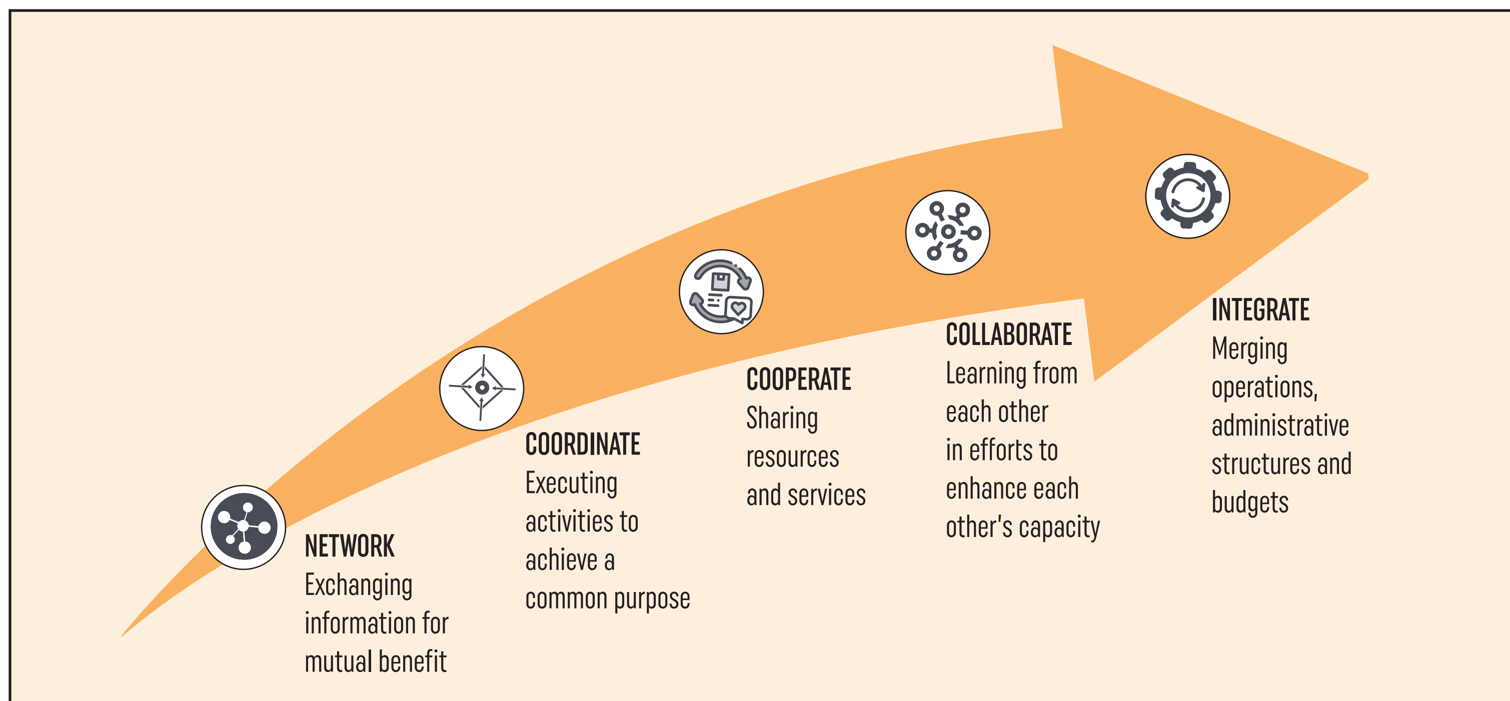
Your respective practice setting influences the daily activities and availability of you and your family medicine team. Some family medicine practice settings are more amenable and available for collaboration with other organizations or community partners. Family physicians should commit to becoming involved in various community partnerships with organizations based on their resources, interests and capacity. Policy, system and environmental change is a team sport, and there are many levels of collaboration with varying degrees of time, resources and expertise required of partners. Carefully consider your work-life balance, compensation, administrative burden, personal well-being and the level of involvement most suitable for you and your team when contemplating lending your expertise to community partnerships.

The Advancing Health podcast episode, Strategies for Building Powerful Community Partnerships, discusses the health care triangle and offers examples of how physician, social service and community member connections can contribute to healthy, equitable communities.

The purpose of an interorganizational partnership is not to collaborate because it makes participants' work in health care easier. The purpose is to collaborate because the anticipated outcome connects to a shared goal or objective. Experts in this space acknowledge that efficient and effective collaborations can be challenging to develop, implement and sustain. However, a mutually beneficial partnership is incredibly valuable because it allows groups to achieve more together than one could ever achieve alone.

Research on organizational change has shown that collaboration lies on a continuum of varying interorganizational models.[18] As we move from left to right across the continuum in *Figure 2*, the potential to accomplish more with collaboration increases. However, each increasing level requires more time, trust and turf-sharing. Take the temperature in your practice setting and determine where you might be able to fall on the continuum of collaboration presented in the figure below.

Figure 2. Continuum of Interorganizational Models



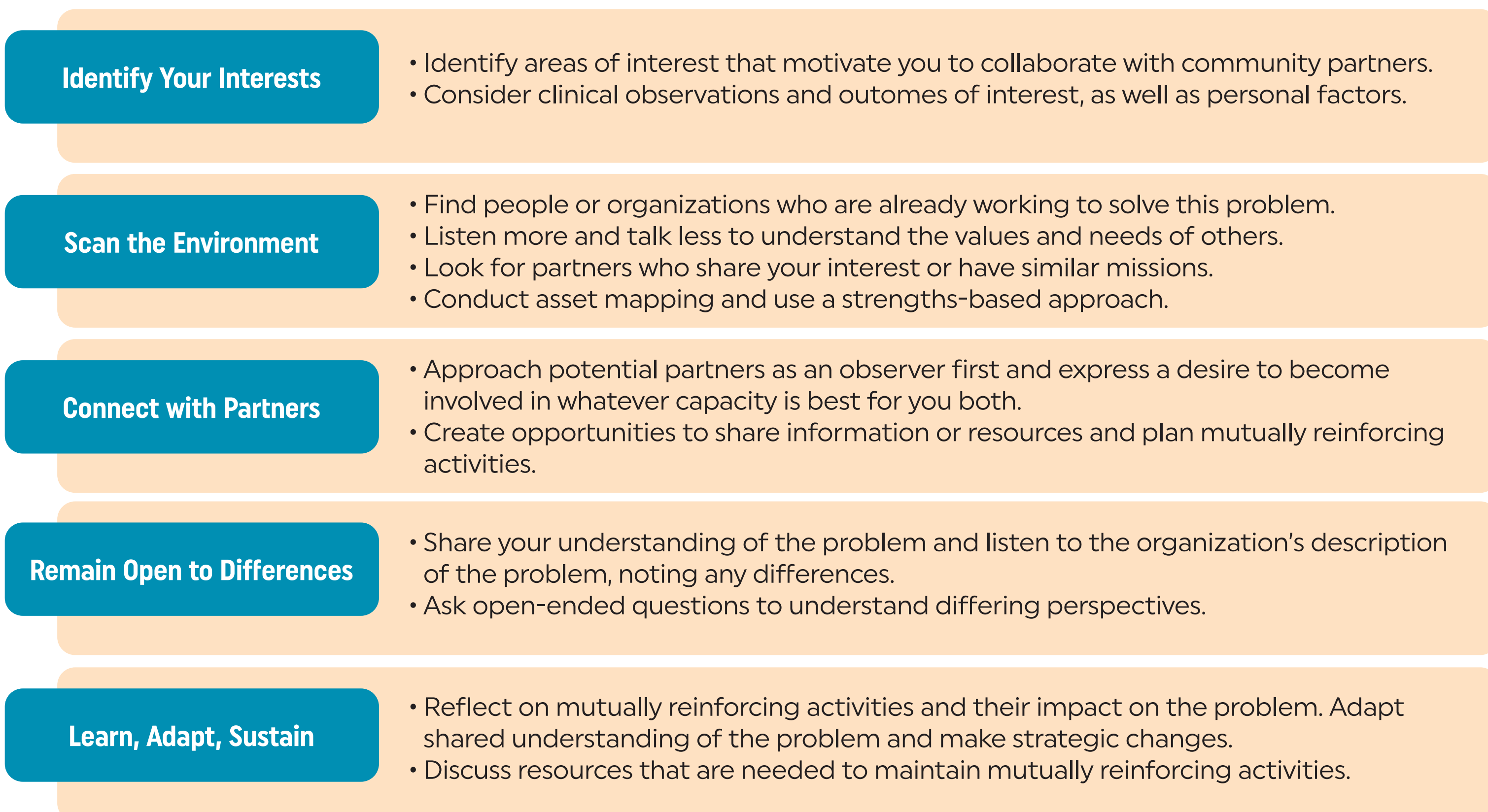
Developed from Mashek, D. Capacities and Institutional Supported Needed Along the Collaboration Continuum, presentation to the Academic Deans Committee of The Claremont Colleges, Claremont, CA.

Summary

Family medicine and public health share an implicit goal to improve community health. Community collaborations look different everywhere, and building trust among community members and organizations takes time. Interorganizational collaborations are often required to make a significant impact on community health. Innovative clinic-community partnerships forming across the nation can generate substantial, lasting improvement in family and community health.

This guide provides foundational information about getting started with community collaboration to integrate public health resources in clinical practice and incorporate clinical insight into community health strategies. There are many options along the collaboration continuum to guide your level of involvement and match your interests. However, many hallmarks endure across a wide variety of collaborations, such as partners sharing health goals, mutually beneficial actions and adapting to fit the community's unique culture.

Figure 3. Determining Community Assets



Developed from information in UCLA Center for Health Policy Research, Section 1: Asset Mapping, https://healthpolicy.ucla.edu/sites/default/files/2023-08/tw_cba20.pdf

Resources

- The Community Tool Box is a comprehensive resource that includes detailed toolkits for various topics related to community improvement, such as conducting needs assessments, communicating to promote interest, planning interventions and working together for racial justice and inclusion.
- Moving Health Care Upstream is a Nemours Children's Health initiative that produced a toolkit, including lesson plans about forming population health integrator networks, data sharing across sectors, building a business case and examples of payment and financing models.
- The Practical Playbook: Public Health and Primary Care Together and The Practical Playbook II: Building Multisector Partnerships That Work guide users through the collaboration process between primary care and public health, providing pragmatic approaches to partnerships and collaborations to address social needs.
- The Community Guide is a collection of evidence-based findings about population-based strategies for improving health. The Community Preventative Services Taskforce of the Centers for Disease Control and Prevention conducts systematic evidence reviews and offers recommendations for community-based interventions and their health impacts based on economic analyses.
- The Population Health Innovation Lab supports multisector collaboration with resources and facilitation, including a guided curriculum called Powering Change: Building Healthy, Equitable Communities Together and its Toolbox for Measuring Cross-Sector Alignment.

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