

PQA SDOH RESOURCE GUIDE COMPANION

Insights on Partnerships for Improving Medication Use Quality





The insights in this companion are based on 15 in-depth interviews PQA conducted between February and July 2025 with individuals from local and national organizations, non-profit organizations and academic institutions, whose work is profiled in the PQA Social Determinants of Health Resource Guide.

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About PQA

PQA, the Pharmacy Quality Alliance, is dedicated to improving the appropriateness, effectiveness and safety of medication use and addressing issues that impact a person's ability to access and use medications. Through quality measurement, research, education and convening, PQA's consensus-driven initiatives help improve health care outcomes and lower costs.

PQA was established in 2006 as a public-private partnership with the Centers for Medicare & Medicaid Services. PQA was created because prescription drug programs were a major area of health care where there was no organization or national program focused on quality improvement. Today, PQA is an independent, non-profit organization with nearly 200 diverse members across health care.

PQA member organizations include pharmacies, health plans, health care providers, pharmacy benefit managers, biopharmaceutical companies, technology vendors, government agencies, associations, health information technology organizations, researchers, accrediting organizations and academia. PQA's work is patient-centered and includes participation from individuals with relevant lived experience, caregivers and advocates.

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Executive Summary

PQA, the Pharmacy Quality Alliance, has published three editions of the PQA Social Determinants of Health (SDOH) Resource Guide. The third edition was published in January 2024 and profiled 40 SDOH services focused on screenings, referrals and interventions focused on improving medication use quality.

Building on the guide's documentation of SDOH programs, this PQA Social Determinants of Health (SDOH) Resource Guide Companion provides insights on key characteristics of effective partnerships that address SDOH barriers affecting medication access, use and outcomes.

From the first-hand perspectives of individuals leading SDOH programs featured in the guide, this companion discusses types of partnerships in SDOH initiatives and some of the strategic approaches and supporting program attributes that are common among programs.

The insights in this companion are based on 15 in-depth interviews PQA conducted between February and July 2025 with individuals from local and national organizations, non-profit organizations and academic institutions, whose work is profiled in the guide. The insights can be applied to develop or strengthen SDOH programs.

There is enormous variation in how SDOH programs are developed and implemented, and that is driven by the local nature of SDOH barriers and the unique resources available to address them. Effective SDOH work is fluid, nimble and responsive to the evolving environment and community needs.

Across the programs featured in the guide, there is a clear commitment to invest time and resources to build partnerships in the community that address the needs of patients and beneficiaries. In those partnerships, several strategic approaches and supporting program attributes were identified as important to success:

Strategic approaches

- Identifying one key SDOH barrier to address
- Assembling a skilled team
- On-site engagement
- Partnering with a community-based organization
- Defining measurable success

Supporting attributes

- Mission alignment
- Adaptability
- Project champions
- Communication
- Humanity

For each strategic approach and attribute, this companion provides (1) insights on why it matters, (2) how to use it in partnerships and (3) markers of success. This information is bolstered by real-world examples that bring the concepts to life.

This companion builds on PQA's work to document SDOH programs that are addressing barriers that impact medication use quality. In addition to spotlighting important work that is improving patient experience and outcomes, this companion provides ideas and inspiration for new and expanded efforts to address SDOH barriers.

Introduction

Social determinants of health (SDOH) are the conditions or places in which people are born, live, work and age that affect their health outcomes. PQA's work includes a focus on SDOH because addressing these factors is important to advancing medication use quality and helping individuals achieve good outcomes.

PQA has published three editions of the PQA Social Determinants of Health (SDOH) Resource Guide. The guide documents real-world SDOH services that are promising for improving the quality and safety of medication use. It is focused on SDOH screenings, referrals and interventions conducted by or involving pharmacists or pharmacies.

Initiatives profiled in the guide have harnessed the power of collaboration, forging partnerships across health care sectors and community organizations. These alliances enable a more holistic approach to addressing SDOH barriers and maximize the reach of interventions. Emphasizing community engagement has been a cornerstone of success. Effective initiatives actively involve the communities they serve, listening to their unique needs and preferences and fostering trust.

This guide companion builds on the first three guide editions and provides insights on the structure and key characteristics of effective collaborative partnerships to address SDOH barriers that affect medication access, use and outcomes.

From the first-hand perspective of individuals leading SDOH programs featured in the guide, this companion discusses the types of partnerships in SDOH initiatives and the strategic approaches and supporting program attributes that are common among the programs.

PQA is grateful to its member organizations and stakeholders for sharing details about their SDOH partnerships through numerous conversations and email exchanges. The perspectives and experience shared form a framework that organizations can apply to develop or strengthen their own SDOH programs.

PQA welcomes feedback on this guide companion. Feedback can be provided to PQA by email at Education@PQA.org.

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SDOH Partnerships: Diverse Teams for Community-Specific Needs

Effective partnerships are a common theme among successful SDOH initiatives. While an SDOH initiative can be promising when led by a single organization, collaborations with community-based organizations (CBOs) can leverage additional strengths and resources. These added capabilities are important because every community is different and has diverse health-related social needs (HRSN).

There is no one-size-fits-all approach to partnerships, and SDOH programs rely on unique partners to address the needs of target populations. The structure of collaborations also varies. In some models, all partners play an equal part in decision making; while, in others, key partners develop the strategy and then engage CBOs on implementation. Some groups found success by having all partners at the table for discussions, while others preferred to develop strategies among a small group and then communicate applicable information to separate teams.

Multiple Approaches to Patient and Community Services

SDOH programs frequently establish relationships with CBOs to provide services directly to patients. From food banks to delivery services, CBOs serve as a conduit between patients and local community resources. They are embedded in the community, directly engage the patients being served and understand the culture. Some programs rely on CBOs to complete initial needs assessments and to identify eligible patients. Others rely on CBOs primarily to connect patients with community resources and provide direct care.

Some pharmacy-based programs have found success in expanding the role of pharmacy technicians to function as dedicated community health workers, providing CBO-type services. This strategy allows staff to identify and manage HRSNs right at the pharmacy.

Keys to Sustainable Programs

Across many SDOH partnerships, two issues are critical for sustainability: funding and data. Most organizations need dedicated funding to significantly engage external partners. The ability to navigate and sustain grants or reimbursement for SDOH services is paramount.

Related, the ability to document SDOH services to share information with partners and to demonstrate value to payers and stakeholders is important. Well-integrated health information technology enables better data collection, improves evaluation and highlights effective interventions.

Strategies and Approaches that Support Success

While each collaboration identified via interview was unique in its makeup, SDOH barrier focus, resources, longevity and success, they were not unique in the characteristics that fostered development and growth of the partnership. It became clear that specific skills and approaches were necessary for any partnership, regardless of its focus. Those qualities have been grouped into strategic approaches and supporting attributes in the following sections. These SDOH program attributes are not exhaustive, but representative of the most prominent skills noted in the interviews.

Strategic Approaches for SDOH Partnerships

The SDOH partnerships profiled in the guide deploy a variety of strategies to address the needs of their communities. In interviews with project leaders, five strategic approaches were frequently mentioned as important factors in their success. This section provides details on those strategic approaches, why they matter, how they can be built into partnerships and markers of success.

STRATEGIC APPROACHES FOR PARTNERSHIPS

1. Identifying one key SDOH barrier to address
2. Assembling a skilled team
3. On-site engagement
4. Partnering with a community-based organization
5. Defining measurable success

1. IDENTIFYING ONE KEY SDOH BARRIER TO ADDRESS

Why it matters: Ideas for SDOH programs often originate with a health care system, health plan or public agency that is responsible for a population of patients. These institutions identify key SDOH barriers that prevent their patients or members from reaching optimal health outcomes through standard interventions such as pharmacotherapy. Identifying the focus of an SDOH project is the first step that each organization takes to determine the best possible partner. Rather than trying to address all HRSNs within a community, these partners identified one critical barrier to address. Focusing on one barrier enables SDOH program leaders to concentrate their time, expertise and resources in a specific area, where improvement may be most helpful and where insights gained can be applied to other areas in the future.

How to build it into partnerships

- **Data-informed decision:** Use local health data, claims data or community assessments to identify the most pressing and solvable needs.
- **Define the population:** Identify who the intervention will serve and where (e.g., older adults, rural communities).
- **Define the problem:** Aim for a mission statement or set of goals that narrowly defines the scope and clarify the intervention.
- **Plan for depth:** Once the SDOH barrier is identified, pilot a deep approach before scaling it widely to demonstrate that a focused effort can make a meaningful impact.
- **Operational feasibility:** Match the project's scope to the available staff, funding and timelines.

Markers of success

- Clear population, barrier, and outcome
- Defined intervention scope
- Activities that directly address the SDOH barrier
- Metrics tied to key barrier
- Potential to expand or replicate

KEY TAKE AWAY

By focusing deeply on one defined SDOH barrier or population, partnerships build credibility, evidence and cohesion. They learn what works, refine their approach and position themselves to take on broader challenges in the future.

PARTNERSHIP IN PRACTICE

A cardiologist at Vanderbilt University Medical Center learned about the Los Angeles Barbershop Blood Pressure Study and decided to adapt the model for use in Nashville, Tenn. A clinical pharmacist was identified to work within a collaborative practice agreement, specifically allowing him to monitor blood pressure and provide education on hypertension medications. Although patrons of the barbershop often wanted to discuss more than just their blood pressure, the pharmacist was able to refocus conversations on hypertension and blood pressure monitoring, allowing for measurable improvements in patient outcomes. By having a health care professional meet patients face-to-face in the barbershop, this group was able to improve access to care. Having a pharmacist on site eliminated the need for transportation to a provider's office and allowed patients to seek blood pressure care during their working hours.

PARTNERSHIP IN PRACTICE

The Dispensary of Hope (DOH) is a charitable medication distributor dedicated to increasing access to medication by partnering with pharmaceutical manufacturers and dispensing sites to distribute surplus medications to low-income, chronically ill patients. Their team conducts extensive research to identify geographic areas with the greatest need for free or reduced-cost medications. They collaborate with local clinics and pharmacies to provide medications directly to patients in need. By working alongside national distributors and local clinics, DOH effectively removes the barrier posed by medication costs. By maintaining a focus on improving access to medications, DOH is able to demonstrate reproducible results and improvement in patient care.



2. ASSEMBLING A SKILLED TEAM

Why it matters: Effectively tackling any SDOH barrier requires more than clinical expertise. It requires an interdisciplinary and culturally sensitive team. The composition of the team depends on the SDOH barriers being addressed. Teams can include, but are not limited to, social workers, community health workers, clinicians, pharmacists, dieticians and technology experts. A diverse team is not just helpful, but necessary. When these teams collaborate, it is easier to see the complete picture of the problem and develop more holistic solutions that work for the community. SDOH barriers are multidimensional and require a team with both professional expertise and community insight.

How to build it into partnerships

- **Map skills first:** Consider the projects' needed skills and communicate them clearly in the vision.
- **Recruit strategically:** Seek partners who actively fill specific gaps in perspective or expertise like a faith-based organization or a local expert.
- **Pursue shared learning opportunities:** Build training sessions or workshops that foster a mutual understanding of the assembled teams' skills.
- **Develop a succession plan:** Ensure continuity in skills to maintain momentum when a team member is pulled away or moves to a new opportunity.
- **Highlight skilled team members:** Many skills on a team often go underappreciated. Consider communicating to the community and stakeholders why a particular team has achieved successes in the project.

Markers of success

- Cross-sector representation
- Cross-domain expertise (e.g., clinical, social, financial, operational)
- Clearly defined roles
- Decisions consider all domains at work
- All skills can contribute to defining and achieving success

KEY TAKE AWAY

Engineering success through complementary expertise and skills supports projects that last, delivering what communities need.

PARTNERSHIP IN PRACTICE

Gennesaret Free Clinic assembled a team of experts to implement an SDOH program focused on cardiovascular health and dietary changes. University researchers, clinical pharmacists, dietitians and a national association partnered to write a grant, develop an intervention, roll out a new program and conduct ongoing monitoring. Each member of the team had a separate and vital role in the program's implementation and maintenance. For example, using their distinct skills, university researchers wrote a grant to submit to the state. The clinical pharmacists and dietitians implemented the intervention, while the national association provided educational collateral. Having experts across various disciplines enabled this group to sustain the SDOH program for longer than anticipated in the original grant application.

PARTNERSHIP IN PRACTICE

Partners in Care Foundation (PICF) is a national, non-profit care coordinator, working to connect medical services with CBOs to support patients in living a safer, healthier life. In connecting patients and health care providers with services at the community level, PICF requires a diverse range of expertise or staff that “speak the right languages.” Their team has evolved to include pharmacists, IT specialists, nutritionists, housing specialists, care management professionals and billing specialists, among others. By assembling a team of experts in various areas, communication between health plans and CBOs become more seamless, and coordination to address the community's needs is more efficient.



3. ON-SITE ENGAGEMENT

Why it matters: When multiple groups come together to collaborate on any project, it can be challenging to translate an idea into action. In this situation, on-site engagement, often described as having a “person on the ground,” is important. CBO partners regularly provide this direct engagement. At the beginning of a project, collaboration occurs at a higher, strategic level. Having a member of the project team physically present in the community builds trust with partners and populations. Furthermore, they help facilitate communication between different organizations and provide feedback on project elements to collaborating partners. By acting as a bridge between health providers and the patient, community-based partners can report back on what is happening, catching miscommunications early or aligning services around the needs of the population. Last, this teammate can provide the lived experience of a project intervention and detail the impact in a way that technology and data often miss. They can keep the project grounded in the reality of the community’s SDOH barriers and needs.

How to build it into partnerships

- **Designate early:** Identify the person on the team who will represent the project during the early stages of planning, not as an afterthought.
- **Hire locally:** Recruit the person on the ground from within the community served, when possible. Local hires bring knowledge, context and existing trust to the project.
- **Provide ongoing support:** Field staff should have initial and ongoing training, as well as clear channels for communication with leadership.
- **Have a mechanism for feedback:** Surveys, debrief meetings or dashboards allow the person on the ground to report trends, challenges and community feedback more efficiently.
- **Recognize their role publicly:** Highlight the field staff in communications, reports and evaluations of the program successes.

Markers of success

- Regular community interaction
- A conduit for community feedback
- Observations that lead to project adjustments
- Increased community engagement
- High levels of trust with the community

KEY TAKE AWAY

Having a person on the ground transforms partnerships from conceptual to connected. They turn organizational goals and strategies into human relationships and ensure that interventions are grounded in reality.

PARTNERSHIP IN PRACTICE

The Nashville Black Barbershop partnership with Vanderbilt University Medical Center had a clinical pharmacist act as the “person on the ground,” working daily to establish and build trust with clients and engage them in their own health. The clinical pharmacist bridged the gap between the population’s lived experience and their health care providers, allowing the health care organizations to stay more connected to their patients and understand the community more thoroughly. This team member translated the project idea into action, tracking progress and troubleshooting SDOH barriers in real time. This project demonstrates that the ongoing needs of an SDOH project are difficult to identify and act on without a physical presence in the community.

PARTNERSHIP IN PRACTICE

The partnership between Indiana University Health, Purdue University College of Pharmacy, Gleaner’s Food Bank (GFB) and NourishedRx is an example of a national-local collaboration that depends on having teammates embedded in the community. Having a national partner like NourishedRx brings funding, strategies and logistical manpower. At the same time, food insecurity is highly local as it is tied to access, transportation and cultural preferences. Having a GFB representative on the ground ensures that resources from the national partner are tailored to the realities of the Indiana communities they serve. Patients also may not necessarily feel connected to their large health system, despite its proximity to the community. GFB staff and volunteers are embedded in the local pantries and community centers, where they build trust and engage patients to provide screenings, food education and referrals to other services. They can offer real-time education on the food patients are receiving or provide feedback to the project partners on whether strategies are working in the community. For GFB, the person on the ground is the face of the larger collaboration that might otherwise feel impersonal.



4. PARTNERING WITH A COMMUNITY-BASED ORGANIZATION

Why it matters: Populations with SDOH barriers may mistrust national entities but have a relationship with their local food bank, housing nonprofit or pharmacy. CBOs often have long-standing and trusted relationships with the populations they serve. That trust is critical to increasing engagement in the community and reducing SDOH barriers. CBOs act as a bridge among health care systems, health plans, providers, government agencies and communities. They are uniquely positioned to observe when a program isn't working or an individual has too many barriers to participate in their health care. Because CBOs are rooted in the communities they serve, they can elevate and advocate for those most in need. This often shows up as advocating for changes to transportation or improved neighborhood safety, increasing cultural awareness and providing individualized support.

How to build it into partnerships

- **Map the community early:** Identify the CBOs that are already trusted in the community, then determine which ones might share a complementary mission.
- **Co-design from the start:** Each CBO leader should have a stake in the planning process, applying for grants and evaluating programs.
- **Provide funding:** Have a plan for how to provide direct funding to partner CBOs from the start. Their expertise and involvement in the community is a necessity.
- **Establish CBO leadership:** A committee or council including each CBO leader ensures equality in decision-making.
- **Invest in longevity:** Strengthen CBO capacity by supporting infrastructure, data-sharing agreements and technical assistance.

Markers of success

- CBO representatives in leadership roles
- CBOs as collaborators from program development and evaluation
- Funding for CBOs
- Community engagement in the project

KEY TAKE AWAY

Partnering with CBOs provides local knowledge, resources and trust that can greatly enhance your ability to identify and address SDOH barriers of specific communities.

PARTNERSHIP IN PRACTICE

One of the unique aspects of the Partners in Care Foundation (PICF) is its Care Hub, a network of CBOs across California that are open, accessible and seeking referrals. This hub helps smaller CBOs tap into projects and funding from health plans and health systems, reducing the burden of marketing to large-scale partners. PICF maintains regular communication with CBOs to ensure they receive payment for their services, have the resources they need to be successful and meet their contracting and compliance requirements. By having a network of CBOs, PICF can match partners based on project type, SDOH barriers, demographics, zip code and more. This allows for faster implementation and lower administrative burdens for CBOs. PICF understands the needs of Californians and that local CBOs are strong partners in recognizing cultural differences and tailoring interventions for complex needs. By acting as intermediaries, they can help ensure that all partners in the collaboration are successful in addressing the needs of patients.

PARTNERSHIP IN PRACTICE

The University of Buffalo partnered with CPESN NY and the Independent Practice Association to train pharmacists and pharmacy technicians as community health workers (CHWs) to screen patients for SDOH barriers and refer their HRSNs to CBOs that can help. By expanding the expertise of an existing pharmacy employee, these partners transformed how health care was being delivered in Buffalo. Training pharmacy professionals as CHWs is a powerful tool as pharmacists continue to be the most accessible health care provider. Simultaneously, many aspects of SDOH barriers cannot be resolved at the pharmacy. HRSNs that were identified by CHWs were quickly referred to Buffalo CBOs that could meet that need. This project highlights the importance of innovation in interventions, while also showing that a partnership with CBOs is necessary to close the loop on those interventions, thereby referring and connecting patients to resources more seamlessly. Furthermore, the Buffalo CBOs brought many resources that a pharmacy does not have access to, like faith groups, senior centers, and housing advocates. This multiplies the project's reach and strengthens the network of resources available to the Buffalo community.



5. DEFINING MEASURABLE SUCCESS

Why it matters: When evaluating an SDOH program, setting expectations and defining measurable success are essential. Defining success for a program can involve assessing the program's feasibility, evaluating stakeholder satisfaction and improving patient outcomes. Periodic reviews help identify areas that may need change or improvement, while ensuring that progress is being made towards goals. Evaluating program success is important for process improvement and informing expanded or additional initiatives.

How to build it into partnerships

- **Define success before launch:** Before beginning the project, partners should discuss what success means to each organization and the community; document definitions and revisit regularly.
- **Use shared metrics:** Partners should agree on specific indicators that everyone can measure and report.
- **Integrate success metrics:** Embed success metrics into a memorandum of understanding, an interim evaluation plan or a regular meeting agenda.
- **Include the community:** Engage community members in designing the success measures to ensure outcomes reflect the lived experience.
- **Revisit regularly:** Success should evolve as conditions in health care, technology, or the community do. Revisit the definitions of success regularly to ensure they meet the project's needs.

Markers of success

- All partners use a concise, documented set of goals and metrics
- Partners use similar terms to describe project's goals with the public and stakeholders
- Data are gathered in consistent methods and timelines
- Community is engaged in achieving the outcomes
- Metrics are not static, but change as needed

KEY TAKE AWAY

Having a clear definition of success bridges the gap between vision and execution, ensuring that diverse partners move in harmony toward meaningful, equitable outcomes.

PARTNERSHIP IN PRACTICE

The Allegheny REACH Initiative utilized Centers for Disease Control and Prevention (CDC) funding for its programs. This funding comes with specific directions from the CDC on how to evaluate success, including qualitative and quantitative components. Some metrics considered by the CDC include the number of priority community residents who have increased food security and survey data taken from farmers market vendors. In addition to the CDC-required metrics, the Allegheny REACH Initiative conducted focus groups to gather patient feedback. They also tracked the number of referrals to other partners and hosted large team meetings to report on performance metrics. The Allegheny REACH Initiative understood the value of having multiple measures of success to evaluate its programming. They collected input from their stakeholders and analyzed performance metrics to determine the success of their program before expanding it to larger populations. The Allegheny REACH Initiative also highlighted the importance of documenting and communicating its results to partners to ensure continued alignment on new SDOH programs.

PARTNERSHIP IN PRACTICE

For the team at Outcomes, success was defined early and revisited often, because of the dynamic collaboration among Outcomes, CaringWire, their health plan client, and the frontline pharmacist. Each partner in this collaboration has different goals: pharmacists need quick, usable tools that help patients, health plans need improved outcomes and reduced costs, CaringWire wants its directory to be accurate and used efficiently, and Outcomes wants to show that its platform drives value in the SDOH space. Although all partners have the patient's best interests in mind, with different goals, it can be hard to define what constitutes a successful intervention. Outcomes and CaringWire have a nimble, adaptive relationship that allows them to collect data regularly and adjust the tool accordingly. They take feedback from pharmacists and clients and implement changes quickly, looking for small improvements to previous processes. Having a defined yet flexible definition of success allows the partnership to pivot to meet the needs of those they serve and become a sustainable, scalable solution to SDOH barriers.



Supporting Attributes of SDOH Partnerships

In addition to strategic approaches, successful SDOH partnerships have other attributes that support success. This section provides details on those supporting attributes, why they matter, how they can be built into partnerships and markers of success.

SUPPORTING ATTRIBUTES OF PARTNERSHIPS

1. Mission alignment
2. Adaptability
3. Project Champions
4. Communication
5. Humanity

1. MISSION ALIGNMENT

Why it matters: When organizations come together to tackle SDOH barriers, they bring different strengths: data, community trust, specialized expertise and more. However, without a shared sense of why the work is being done, the strengths of each organization could potentially pull groups in competing directions. SDOH barriers are complex and cross the boundaries of health care, housing, education, transportation and more.

Furthermore, funding can be scarce or hard to secure. Without alignment, groups tackling the same problem may find themselves competing for funds rather than collaborating to optimize resources. Mission alignment ensures that each partner's efforts reinforce the project's vision, rather than fragmenting the work or sewing confusion among partners or in the community.

How to build it into partnerships

- **Discuss the vision:** Engage all partners in discussions around core values, desired impact and what defines success.
- **Define roles:** Each partner needs a clear role that supports the larger mission.
- **Encourage feedback:** As the community's needs evolve, so should the project mission. Ensure a process for feedback so that the collaboration stays responsive to evolving needs.
- **Consider data:** Metrics and dashboards help keep partners focused on the same outcomes.
- **Celebrate wins:** Publicly recognize achievements to reinforce the project's purpose and strengthen buy-in.

Markers of Success

- Values are reflected in actions
- Measures of success are shared and understood
- Partner roles are clear and complementary
- The project evolves and changes with the community's needs
- Partners share data and communicate successes

KEY TAKE AWAY

Mission alignment among partners builds trust, optimizes resources, clarifies mutual roles and benefits and fosters work towards common goals.

PARTNERSHIP IN PRACTICE

The Racial and Ethnic Approaches to Community Health (REACH) grant is a CDC-funded initiative implemented by the Allegheny County Health Department (ACHD), in partnership with over 15 community, health and governmental organizations. Their goal is to address chronic disease disparities in African American communities in specific neighborhoods in Allegheny County by improving access to healthy foods, physical activity, breastfeeding supports and adult vaccinations. ACHD has worked to find many partners to collaborate with on this grant, all of which have their own unique missions yet align on several core themes, including equity, health promotion, prevention, reducing disparities and addressing SDOH. By reaching consensus on who the initiative is for, partners can coordinate outreach and resource allocation. Each partner can take responsibility for their area of expertise, thereby reducing duplication while having confidence that other partners are similarly committed. Their mission alignment allowed the coalition to plan interventions in stages and scale the project to help more people at each phase.

PARTNERSHIP IN PRACTICE

The Alliance for Integrated Medication Management (AIMM) is a nonprofit focused on promoting the wide adoption of team-based comprehensive medication management services. AIMM teamed up with Empire Health Foundation (EHF), a nonprofit, private foundation focused on advancing health equity and quality of life in the Inland Northwest. They worked together, alongside several additional partners, to coordinate medication care for older patients in rural communities. These groups aligned on the project's vision in many ways, including the population focus, the nature and implementation of the intervention, and how to create a sustainable program. Both AIMM and EHF are concerned about populations with SDOH barriers, yet chose to focus on a rural population with complex medication needs initially. By starting with patients with high medication complexity, each group remained true to their unique organizational values while aligning on the project's mission. This meant AIMM integrated medication management into a team-based care model, while EHF improved medication outcomes in Inland Northwest communities. By working together, they built a business case for medication management services in rural Washington state and implemented long-term programs that continue to serve the community.



2. ADAPTABILITY

Why it matters: Adaptability is critical for organizations working together on SDOH initiatives, as the needs of communities are constantly evolving, and the capabilities of partners shift. HRSNs, available resources and partners capacities can change rapidly. The ability to adjust strategies to account for these changes is important for responsive programs and long-term success.

How to build it into partnerships

- **Create a culture of learning:** Hold regular sessions to discuss what is working and what is not; treat adjustments as signs of progress, not weakness.
- **Have flexible leadership:** Decision-making structures must be able to evolve, potentially with rotating leadership or short-term working groups to solve an issue.
- **Start small:** A pilot program lets scope and budget be tested and adapted before scaling up.
- **Get real-time data:** Dashboards or real-time updates allow partners to see changes quickly and adjust strategies accordingly.

Markers of Success

- Partners regularly revise plans based on evidence
- Community members are actively engaged in the ongoing project
- Data is used regularly, not reported annually
- Partners think of change as part of the process, not a disruption
- Leadership encourages experimentation and iteration

KEY TAKE AWAY

Adaptability is about staying true to the mission while adjusting tactics to meet reality.

PARTNERSHIP IN PRACTICE

A large insurance provider partnered with a national nutrition therapy company to deliver healthy prepared meals, meal kits, groceries and nutritional coaching to community members with diabetes. This program started small and has used a phased approach, using real-time data to expand each year and include more patients who face nutritional SDOH barriers. The partners also quickly recognized the importance of partnering with CBOs embedded in communities and familiar with the challenges members face. By learning the community's needs, the partnership adapted to include the CBOs that could deliver the most value. The model of this partnership further allows for tapered services over time. The national nutritional management company adapts its outreach and services provided to meet the particular needs of a patient and gradually wean them from the program when they are ready. Furthermore, all partners are sensitive to cultural food preferences and dietary needs and adapt the program to meet the patient where they are in their nutrition journey. By design, this program adapts to the community and the patient. But more than that, the partnership has continued to adapt and evolve, using data collected from the program and modifying its strategy to better meet community needs.

PARTNERSHIP IN PRACTICE

DC Greens is a nonprofit in Washington, D.C., whose mission is to advance health equity by building a just and resilient food system. They partner with health care providers and clinics, as well as local grocers, to provide healthy food to the food insecure in their communities. The program has changed its process over many years to better adapt to the needs and requests of its partners, as well as patients. How patients pay for and acquire fresh produce, how they communicate with health care providers, and how they collect data on the program has all changed. By demonstrating that the program is adapting to the needs of their partners and patients, they have secured funder buy-in, further enabling sustainability and expansion to help more people. This program is a strong example of how adaptability is a necessity in SDOH work as environment and patient needs are not static.



3. PROJECT CHAMPIONS

Why it matters: It is essential to have a project champion to build support and buy in, ensure resource allocation, navigate organizational challenges, drive project momentum, and enhance collaboration on an initiative. Having leadership buy in helps ensure alignment with the organization's strategic goals, streamline efforts to gather resources for the project and build internal support. With resources secured, the project champion can help with allocating time and funds to the project. Project champions help navigate challenges and resistance, communicate a clear vision and take ownership of the project's success.

How to build it into partnerships

- **Identify potential champions early:** Rather than hoping a project champion emerges by chance, try intentionally designing for one. Each partner should prioritize identifying champions with respect and credibility within their organizations and communities.
- **Define the role:** Outline clear expectations of the champion to prevent burnout, confusion or duplication of effort.
- **Provide resources and authority:** Allocate time on the project, administrative support and discretionary funds to sustain the project and legitimize the role.
- **Embed in governance and support succession:** Formalize the role on a leadership team or committee and train the champion with a successor from a partner organization to ensure continuity.
- **Measure their impact:** Recognize the champion's contributions in reports, presentations and evaluations to reinforce the importance of the role.

Markers of Success

- Credibility within their own organization and external stakeholders
- Strong communication to motivate and connect partners
- Persistent, despite external or competing pressures
- Strategic to secure leadership attention and redirect resources when needed
- Demonstrated commitment to helping those most affected by SDOH barriers

KEY TAKE AWAY

Champions sustain alignment, bridge systems and keep community needs at the forefront. Without them, even the best-designed partnerships risk losing direction or impact.

PARTNERSHIP IN PRACTICE

The Alliance for Integrated Medication Management (AIMM) is a facilitator and strategic planner of team-based comprehensive medication management services. When partnering with other groups, they have found that when a project champion is clearly labeled, the project runs more smoothly. In the Medication Care Coordination (MCC) program, each partner identified project champions, allowing AIMM to coordinate with each group while communicating only with the project champion. Those champions brought many skills and character traits to the MCC project that made it successful: passion for reducing SDOH barriers and improving medication access, connections within the local community to improve relationships and energy to keep the project moving forward, even in the face of delays or challenges. While AIMM provides strategy, logistical tactics, and expert guidance, they still agree that a local project champion is necessary for success.



4. COMMUNICATION

Why it matters: Communication is more than sharing information. It is building understanding and trust across sectors with different skill sets. Poor communication can lead to duplicated efforts, broken trust and missed opportunities, while effective communication can bridge cultural, organizational and professional gaps among project partners.

How to build it into partnerships

- **Establish definitions:** Aligning partners on terminology will prevent confusion and ensure each partner interprets goals consistently.
- **Create structured communication channels:** Whether it is regular meetings with an agenda, or a digital dashboard, have one place for updates from all team members.
- **Have a lead communicator:** Identify one person, or a small team, to be responsible for managing updates, documenting decisions and maintaining engagement across organizations.
- **Practice bidirectional communication:** Pushing information out is important, but inviting feedback is equally valuable.
- **Adapt communications:** The use of many different methods – briefs, infographics, plain language – allows the project to reach broader audiences.

Markers of Success

- Partners use the same language to describe the project, its goals, activities and accomplishments
- Community members feel informed and engaged
- A feedback loop exists and is active, where partners act on information received
- Project decisions are transparent
- Progress updates are widely accessible to partners and the community

KEY TAKE AWAY

When communication is intentional, inclusive and ongoing, partnerships remain aligned, communities feel heard and goals are achievable.

PARTNERSHIP IN PRACTICE

Dispensary of Hope (DOH) is a charitable medication distributor that works with partners on multiple levels to get surplus medications into the hands of community members that need them. Because the DOH must coordinate with manufacturers, dispensing sites and stakeholders across the country, effective communication is an absolute necessity. From the first meeting with a potential new dispensing site or 10 years into a partnership with an international manufacturer, communication about the mission, shared goals and perceived value must be discussed regularly. Frequent communication about medication supplies, patient needs, distribution methods, and inventory cycles helps all partners have reasonable expectations and actively builds trust with the DOH. Further, DOH communicates its performance to partners first: the number of prescriptions filled, patients served and decrease in hospital admissions are all data points that are shared with partners. Without those valuable partners in the medication supply chain, the work of DOH would not reach as many communities as they do.

PARTNERSHIP IN PRACTICE

When DC Greens was just getting started as an organization, they prioritized consistent and thorough communication with their stakeholders, clinics and grocery partners. During regular meetings, DC Greens never lost sight of the fact that this program needed to benefit everyone: patients, grocers and health care providers. They believe that all team members play an important role in a patient's overall health, and that regular communication about strategy, barriers and successes allows all partners to be heard. The program has evolved over the years since its establishment, but its prioritization of regular communication is a mainstay of their program design.



5. HUMANITY

Why it matters: Humanity, as demonstrated through empathy, reflection and awareness of community needs, is essential for success in SDOH partnerships. SDOH work requires more than coordination, it requires compassion. By focusing on the lived experiences of the communities they serve, SDOH project leaders create more effective, purpose-driven programs.

How to build it into partnerships

- **Storytelling:** Start meetings or presentations with a patient, caregiver or community story.
- **Prioritize empathy:** Leaders and champions must model empathy, acknowledge uncertainty and practice active listening.
- **Center the community's voice:** Establish groups of community members with lived experience, who can advise the project.
- **Celebrate contributions and successes:** Highlight human effort – from data entry to patient navigators, each person plays an important role.
- **Use inclusive language:** Review all materials and coach team members to ensure they prioritize respectful and inclusive language.

Markers of Success

- Community members are involved in project design and evaluation
- Meetings include time for open discussion, empathy, storytelling, gratitude and reflection
- Partners reference people, not just metrics or data
- Decisions consider moral and social impact alongside financial or operational metrics
- Program materials reflect dignity and respect in tone and imagery

KEY TAKE AWAY

In SDOH work, where trust, equity and community engagement are paramount, leading with humanity ensures that the systems built to serve people never lose sight of the people at the center of the work.

PARTNERSHIP IN PRACTICE

The Dispensary of Hope (DOH) not only prioritizes humanity but lives it through every partnership, recognizing that access to medicine is not just a system issue but also a moral and human one. While searching for partners in a specific community, they make sure to lead with this value, because they have found that those partners who also prioritize humanity both in their mission statement and in their daily work are generally successful partnerships. They prioritize workflows with their partners that allow patients to acquire medications in clinics and pharmacies, rather than a stand-alone building or process that makes people feel singled out. They are also diligent in their language around dispensing of charitable medications, referring to them as “access programs,” thereby further preserving the dignity of the community. Furthermore, DOH launched the “Hero of Hope” award, given to partners who understand the mission, fully commit to helping their community in partnership with DOH, and change their processes to better serve the patients and frontline workers. DOH knows that the strength of their partnerships comes from the shared compassion for medication stability and continuing life-saving treatment for those who need it.

PARTNERSHIP IN PRACTICE

The partnership between the Gennesaret Free Clinic, Purdue University for Health Equity and Innovation and Gleaner’s Food Bank shares a goal of improving health equity and addressing basic needs like food and health care. Within that goal, every partner is dedicated to using respectful and culturally sensitive language that builds trust with patients, including “health and hope” and “health care is a human right.” They communicate openly and regularly with the populations they serve, including eligibility criteria and the center’s opening hours. Furthermore, these groups have made an effort to meet patients where they are physically located by employing mobile clinics, reducing the barrier of transportation and eliminating the stigma associated with the method of travel. Last, the executive director for the clinic leads by example in team meetings, press interviews and patient appointments, always keeping the project mission at the forefront. This top-down method of exemplifying humanity gives the rest of the team a blueprint for how to operate. This group has prioritized humanity and mission alignment, allowing them to provide equitable care in a creative way that honors those they serve.



Acronym List

AIMM	Alliance for Integrated Medication Management
CBO	Community Based Organization
CDC	Center for Disease Control
CHW	Community Health Worker
CPESN	Community Pharmacy Enhanced Services Networks
DOH	Dispensary of Hope
EHF	Empire Health Foundation
GFB	Gleaner's Food Bank
HRSN	Health-related Social Need
LABBPS	Los Angeles Barbershop Blood Pressure Study
PICF	Partners in Care Foundation
PQA	Pharmacy Quality Alliance
REACH	Racial and Ethnic Approaches to Community Health
SDOH	Social Determinant of Health
VUMC	Vanderbilt University Medical Center

Advancing Access and SDOH

PQA, the Pharmacy Quality Alliance, is dedicated to improving the appropriateness, effectiveness and safety of medication use and addressing issues that impact a person's ability to access and use medications. Publications like this PQA Social Determinants of Health (SDOH) Resource Guide Companion are part of PQA's work to address access issues through research, education and convening initiatives.

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Give Us Your Feedback

PQA welcomes your feedback on the format, impact and utilization of this guide. Additionally, if you are working on SDOH or access initiatives relevant to PQA's work to advance medication use quality, we want to hear from you. Please email all feedback to Education@PQA.org.

Access this Guide Companion

The PQA Social Determinants of Health (SDOH) Resource Guide Companion was designed to be widely used by the public in many different settings. You are invited to download and share this guide. Visit PQA's website to access this companion and other Reports & Resource Guides.



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