Communities Joined in Action
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Critical Factors in Cross-sector Health Partnerships: Charting a More Promising Future

Communities Joined in Action
RWJF Aligning Systems for Health Initiative

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Executive Summary

This study provides insights into how internal factors such as organizational structures, functions, and leadership engagement, and external factors such as public policies, power dynamics, and stakeholder engagement impact cross-sector partnerships. The intent is to describe the practical realities, with attention to how the community voice is reflected.

How does engagement occur, and how is trust built?

What are the opportunities and challenges of partnerships at different geographic scale?

How do partner roles and contributions impact the achievement of goals and objectives?

Engagement of community stakeholders, particularly lay residents in cross-sector partnerships varies significantly, and genuine participation is often limited. Geographic scale has important implications for institutional engagement, public policy, and community participation. With these and related issues in mind, six sites were selected for analysis, including two regional, one rural county, one city, and two community level partnerships. Four key interviews were conducted at each site: one each with a leader representing health care, partnership management, a related sector, and the community.

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Five of the six partnerships rely primarily upon partner contributions and competitive grants from private philanthropy. Given periodic fluctuations in balance sheets and changing priorities with private philanthropy, each organization spends substantial time and effort to address ongoing budgetary needs. All six cited trust building as a significant accomplishment that has overcome decades of neglect and broken promises.

Informants identified challenges that have been reported in the media since the onset of the Covid-19 pandemic, including a rise in mental illness, substance abuse, food insecurity, and domestic violence. On the positive side, interviewees shared the view that trust established through their partnerships facilitated resource sharing that has helped to ameliorate the negative impacts of the pandemic. Informants acknowledged the fragility of their partnership structures, and the importance of strong mediation. Just as some emphasized the importance of training for community residents in these partnerships, others emphasized similar needs for institutional representatives, ranging from education about community history to encouragement to “leave the suit and tie at home” to reduce intimidation that impedes open communication.

Executive Summary *(continued)*

Informants identified historical and/or structural dynamics that in one way or another either impede or enhance progress towards identified goals and objectives, ranging from intimidating communication styles among institutional partners and control of funding priorities to the delegation of engagement to organizational representatives without decision making power. Others cited a lack of resources for leadership development for community-based organizations, which serves as an impediment to working in collaboration with others.

Health care informants cited movement towards risk-based reimbursement but acknowledged that most hospital investments in social determinants of health to date are driven by commitment to charitable mission. Some pointed to the need to be more intentional in allocating responsibilities among those best positioned to provide services in the most cost-effective manner. Others emphasized the need to diversify revenue streams, bringing in contributors outside the physical health arena to reduce the demand for preventable health care utilization.

Key Conclusions

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- **Increased geographic scale** offers advantages in the rationalization of services, but limits sensitivity to the needs of diverse communities.
- **Competitive dynamics "die hard"** among health care providers and payers, often perpetuated by delegation of participants to those not in a decision-making role and/or limiting the scope of acceptable topics.
- **Partnerships typically struggle for financial stability**, given a high reliance on the limited time frames of private philanthropy.
- **Strong justification for genuine community engagement** at every geographic scale, with dividends ranging from mobilization and support of interventions to building political support to minimize turnover of local elected officials.
- **Partnerships often lack the connections, resources, expertise, and leverage to** proactively engage government agencies in a planning process that links innovation to policy development.

I. Introduction

Purpose

The purpose of this study is to provide insights into cross-sector partnerships and factors that either ***impede or accelerate*** achievement of definitive goals and objectives. As an organization committed to support of community partnerships and shared learning across the nation, Communities Joined in Action (CJA) welcomes the opportunity presented by the RWJF Aligning Systems for Health initiative to provide an in-depth examination of the structures, functions, relationships, and policy dynamics in these complex partnerships.

This inquiry examines how ***internal factors*** such as organizational structures, functions, and leadership engagement; and ***external factors*** such as public policies, power dynamics, and approaches to stakeholder engagement impact cross-sector partnership ***design, functionality, and sustainability***. Our intent is to inform other partnerships across the country, both in the proactive identification of factors that may impede or enhance efforts, as well as build an understanding of actions that have taken by stakeholders to overcome obstacles.

While this study includes documentation of achievements, the primary focus is on partnership dynamics; ***why*** they came together, ***how*** they have evolved, ***in what ways*** they are influenced by these factors. Our intent is to describe the practical realities faced by stakeholders with the courage and passion to form these partnerships, and how they influence stakeholders from different kinds of institutions in related sectors. As a community-focused organization, CJA is particularly interested in ***how the community voice is reflected*** in diverse partnerships and settings. How does engagement occur, and how is trust built? What are the ways in which partnerships at different geographic scale and build trust, and in what ways does this impact the achievement of what kinds of goals and objectives?

Background

Engagement of community stakeholder groups and particularly lay residents in cross-sector partnerships varies significantly, and genuine participation in design, planning, implementation, evaluation, and associated forms of decision making is often limited. There are practical reasons why this is a challenge, not least because those with limited resources and support have less time and flexibility to participate in time consuming processes not directly focused on meeting near term individual and family needs.

We know that overcoming proprietary orientation and competitive dynamics among health care organizations is an immense obstacle to genuine engagement. We also know that the assumption of increasing financial risk to keep people healthy and out of acute care facilities requires a fundamental shift in mindset, strategy, and action. In many, if not most cases, health care institutions approach this important work with a project mentality, designating responsibility to one or more individuals in the organization who are often unconnected to core operations and organizational decision making.

Many institutions and organizations in related sectors have operated for decades with inadequate resource allocations from federal and state public sector agencies, and often lack the capacity to take on new responsibilities and new innovations. Decades of underfunding have contributed to a "brain-drain" in our local public health agencies,[1] with growing percentages of leaders retiring and others choosing other career paths that offer greater potential for advancement and opportunity to make a difference.

While private philanthropy is viewed as the entity best positioned to fund innovation that creates a template for policy development, funds are often spread too thinly in the interest of "spread," and for too short of a period to produce the measurable outcomes demanded by boards. Community-based organizations often find themselves competing with others for the same limited philanthropic resources. The net effect of the withdrawal of federal public sector safety net support has been to delegate conflict over resources from state and federal agencies to local organizations and private philanthropy.

There is growing attention to the need for a common management and oversight structure to serve as a neutral convenor, facilitator, and monitor of these complex partnerships.[2] [3] The introduction of the concept of a "backbone"[4] entity provides an elegant framework and criteria to support definitive and sustainable action by these partnerships. Experience since the advancement of this concept almost a decade ago suggests that practical realities, not only those outlined above, but most significantly in the form of institutional racism presents an additional layer of challenge for communities of color as these partnerships seek to make a meaningful and sustainable difference in peoples' lives.[5]

The geographic scale of a cross-sector partnership also has important implications for institutional engagement, public policy reform, and community participation. Many believe that in order to secure robust participation of community members, it is necessary to focus at a neighborhood or multiple neighborhood scale, typically a subset of a municipality or other jurisdiction.[6] Others suggest that a partnership at the scale of a municipality or county provides a level of accountability and public sector engagement that offer greater potential for achievement of identified goals and objectives. Still others see potential with cross-sector partnerships at the regional scale, involving multiple jurisdictions that are challenged to break down silos and align resources offers higher potential for achieving measurable impact and securing support from state agencies and implement policy reforms.[7] To date, no definitive results have led private philanthropy or the public sector to choose among these options. With these questions in mind, we selected six sites for analysis, including two at the regional level, one rural county level, one city level, and two community level partnerships.

II. Methods

Site selection was carried out with input from CJA board members and other colleagues in the field with experience working with community health partnerships. Criteria for participation were as follows:

1) Cross-sector partnership

2) Engagement of hospitals and other health care stakeholders

3) Engagement of diverse community stakeholders

4) Shared governance and decision making

5) Common metrics and monitoring systems

Additional considerations included diversity in a) population type (i.e., urban, suburban, rural), b) scale (i.e., community, municipal, county, region), c) race, ethnicity, and culture, d) state/local policy dynamics, and e) geography. Attention was given to partnerships that currently or previously participated in national or regional initiatives, both as a source of information and to examine whether key aspects of stated goals and objectives were achieved and/or sustained.

A total of 24 key informant interviews were conducted with representatives from six cross-sector partnerships; one each with a senior representative of a partner health care organization, a related sector organization (e.g., local public health agency, social services agency, higher education institution), a community-based organization or local resident leader, and the lead for the organization that manages the partnership. One-hour interviews we conducted with each participant. Interviews were recorded and conducted virtually with video to capture complete information and foster an environment of trust and engagement. Data were supplemented with two virtual focus groups at the end of the inquiry that included social service, health care, public health, and community residents from across the country.

The interview guide included five sets of questions; one set of overarching questions for all key informants, and four sets targeted to each of the four categories of interviewees. Interviewees were notified that while sites, and in some cases, interviewees would be identified in the documentation of positive accomplishments, documentation of challenges would preserve the confidentiality of informants and their sites. The intent was to foster optimal candor to help inform the field and minimize the potential to contribute to negative feelings among local partners. Airing issues in a non-specific manner may contribute to necessary dialogue among these partnerships to chart a path through near term obstacles to definitive progress. Profiles of the sites and partnerships are provided in Appendix A.

III. Findings from Overarching Questions

All key informants were asked a set of questions focusing on basic elements of their partnership (e.g., funding sources, accomplishments), the impact of COVID, challenges (e.g., key stakeholders not currently at the table, historical/structural dynamics, the role of public policy, and the impact if the partnership were to end.

Funding Sources

Apart from the **Central Oregon Health Council (COHC)**, which secures most of its funding through a state formula associated with the Coordinated Care Organization structure, the other five partnerships rely primarily upon the contributions of partners and competitive grants from private philanthropy. Given periodic fluctuations in organizational balance sheets and changing priorities with private philanthropy, each organization is challenged to direct substantial time and effort to address ongoing budgetary needs.

Proviso Partners for Health (PP4H) began as a community resident-driven partnership that was later supported by private philanthropy; in recent years, the primary source of funding has been through Loyola University Health system. **Hope Rising (HR)** secures half of its funding from private philanthropy, and the other half from local providers and a regional health plan. **Collaborative Cottage Grove (CCG)** secures most of its funding from private philanthropy and receives periodic grants from partners.

Trenton Health Team (THT) secures approximately 60% of its funding from federal, state, or private foundation grants, 35% from health information exchange member payments and manage care contracts, and 5% from individual donations. It was launched through a founding donation of $1 million associated the closing of Mercer Hospital in Trenton. The **Michigan Health Improvement Alliance (MiHIA)** secures most of its funding from partners and private philanthropy. They have also received some grants from the Michigan Department of Health and Human Services.

Accomplishments

All six partnerships cited trust building as a significant accomplishment among community organizations and residents to overcome decades of neglect and broken promises and in terms of data, strategy, and resource sharing among competing organizations.

PP4H identified efforts to address food insecurity, establishment of a community leadership academy focused on skill building, agency, empowerment, and small business development. Perhaps most importantly, this agenda was established by community residents and institutional partners share resources and expertise. **HR** cites their most significant accomplishments as increased capacity to serve homeless populations and establishment of a safe RX program that has significantly reduced opioid prescribing. More broadly, they point to their longevity (4 years to date), securing 501c3 status, and the sharing of resources across competitive lines. **CCG** successfully established a community health center in the neighborhood and secured city support for revitalization of a local park. One of the most significant accomplishments was securing housing authority support for

enforcement of a public ordinance in a multi-unit housing complex that led to a change in ownership and significant improvements in living conditions.

COHC points to the breadth of sector representation on their board (e.g., education, transportation, business), the completion of regional health assessments and improvement plans, and having built shared knowledge about the interconnectedness of issues impacting health. **THT** cited their emergence as a clearinghouse for a broad spectrum of services undergirded by a robust health information exchange, providing the basis for inclusive analysis and problem solving, among organizational partners and residents. One of the most significant accomplishments for **MiHIA** has been a willingness among four competing hospital CEOs to share best practices, and securing agreement on a comprehensive portfolio of activities, including securing millions of dollars to provide expanded access to high-speed internet connections, effective mapping of strategies to address opioids, ACES, perinatal quality, parenting, and trauma informed care.

Impact of Covid-19

The partnerships identified challenges that have been reported in the media since the onset of the Covid-19 pandemic, including a rise in mental illness, substance abuse, youth suicide, food insecurity, and domestic violence. Because so many in these communities struggled economically before COVID, they face particular challenges to come back in the context of a broad economic downturn. In the Chicago region, one **PP4H** interviewee lamented that there is poor food quality in charitable distribution networks, and cuts in services such as bus lines have disproportionately impacted communities who depend upon them. For **THT**, the review and analysis of data on the impacts of COVID has brought into sharp focus the distinction between the affluence of Mercer County and the concentrated poverty in the city of Trenton. For local partnerships like **CCG** where low-income community residents play a central role, interviewees share that many express a sense of hopelessness and resignation, indicating a reluctance to engage and "just survive for now." In this environment, residents continue to see evidence that their lives are less important than others.

On the positive side, interviewees shared the view that the prior establishment of their partnerships have helped to ameliorate the negative impacts of the pandemic. The response to the challenges associated with multiple wildfires in recent years for **HR** has set the table well for dialogue, resource sharing, and strategizing. There is both pride about their preparedness and an imperative to protect the gains secured by bringing people together to solve problems and align institutional resources. For **THT and MiHIA**, having hospital system leaders already at the table has increased dramatically to coordinate efforts, including sharing of PPEs and medications. The data highlight health inequities and emphasize the need to further enhance interoperability. These partnerships have played a key role in identifying gaps in services and equipment and serving as a central clearinghouse for equitable distribution. For many, it demonstrates the value of a backbone organization, and has contributed to a new level of respect and collaboration among the partners.

All six partnerships acknowledged some delays in the advancement of initiatives. **COHC** described the need for a "now, near, and far view," as work has been disrupted, meetings went virtual, and many of the health care and related sector staff experienced challenges with bandwidth. For health care partners, the entire business model has had to be set aside for the time being. At the same time, everyone has a new appreciation of the need to innovate faster. In essence, there is increased sensitivity to the need to put money upstream, but increased fear that returns will be insufficient in the near term to avert negative financial outcomes. Moving forward will be further challenged by the anticipation of a significant budget shortfall for states as well as institutional partners.

For **CCG**, COVID has slowed down planning for expanding the vision of the Avalon Trace housing complex, (e.g., a $4 million fundraising campaign for housing initiatives in 2020 will not be achieved) they have a financing plan, advocacy plan, research plan for 33 other sites in Greensboro. Local partners are gratified with how so many have stepped up, but the shift to virtual revealed that many people do not have internet access. One interviewee noted that a group of local children do their schoolwork outside their community center to secure internet access.

Stakeholders *Not* at the Table

Interviewees were asked whether stakeholders key to their long-term success were currently under-represented in their partnership. One interviewee shared that there is a tendency among health care partners *not* to support engagement of competitors, driven in part by a desire to seek "ownership" of communities. In another site, the Mayor sees the partnership as "owned" by a major healthcare stakeholder, and an opportunity to focus his time and efforts elsewhere. A public health interviewee noted that engagement of her department is viewed by their public hospital as "having the county covered," representing a missed opportunity to better manage care across providers, as the county hospital is a major source of care.

Multiple interviewees also identified the faith community as missing from the table, and others identified organizations serving the Latinx and tribal communities. Interviewees from **COHC** and **THT** cited a need for more robust engagement of local businesses, local chambers of commerce, and organizations in health-related sectors.

CCG key informants indicated that it is a struggle to get local schools to participate and also called for deeper engagement of the Greensboro Transit Authority to address the inadequacy of routes in serving the Cottage Grove community. One **MiHIA** interviewee expressed an interest in greater participation of local governments, city councils, and mayors, noting disparities in the financial power of different municipalities in the region that leads to under-representation of the interests of smaller cities.

Historical/Structural Dynamics

Key informants were asked to share their observations on what historical and/or structural dynamics are in play in their partnership that in one way or another either impede or enhance progress towards identified goals and objectives.

One interviewee cited a disconnect between institutional researchers and communities that is perpetuated by communication styles that are intimidating and reinforced by the fact that funding priorities are driven by institutional, rather than community interests. Another informant suggested that health professionals and researchers need coaching on how to genuinely engage residents.

> *"They are not aware of the implicit racism that is at work."*

Another informant cited a significant shift in the quality of organizational representation when senior leaders of larger institutions delegate engagement to others without decision making power. When this occurs, it undermines the quality of collaborative working relationships.

One structural obstacle to progress cited by informants is a lack of resources for community leadership development. Many people start as the receptionist in key community-based organizations and rise to the executive director role without access to leadership skill building, or the connections, tools, and resources to grow. This serves as an impediment to working in collaboration with others. Organizations never acquire the readiness to move beyond their initial operational structure.

For **COHC,** a key feature is that each key organization only has one vote, regardless of their relative size and financial power. This represents forward thinking consistent with a comprehensive vision of health, where all share ownership. At the same time, the council was impacted by a recent election that replaced key county commissioners who had played important roles in driving the process. Future success will require proactive and definitive action, both to ensure robust engagement of all partners, and providing education as necessary when there are changes in representation.

For **CCG**, historical and structural dynamics center on issues of race, culture, and class. On one level, the partnership faced challenges in building trust and engagement among Blacks, Latinx, refugee immigrants, and poor white residents. Much has been accomplished in the last four years, and there is deeper appreciation for other peoples' backgrounds. Building trust with institutional representatives who own the resources and associated status is a continuing challenge.

Balancing the power and influence of large institutions with the interests of community stakeholders is a continuing challenge for **THT** and **MiHIA**. When it began, **THT** had a primary focus on health care, and power dynamics still favor the large hospital systems around the table with small non-profits, but a strong focus on the social determinants of health provides some balance. The partnership also benefits from an overriding view that the city government needs the partnership to address issues beyond their capacity. For **MiHIA**, competitive dynamics among institutions are managed to some degree through the launch of multi-level initiatives that are aligned with larger organizational

objectives (e.g., THRIVE). This contributes to engagement driven by a desire to protect their influence and justify their existence.

Role of Public Policy

Key informants were asked to identify the development or absence of public policies at the local, state, or federal level that have or could in one way or another enhance or impede their achievement of goals and objectives.

At least one partnership (**PP4H**) pointed to the Affordable Care Act in general and Section 501r specifically as important federal policy that drives more formal engagement of tax-exempt hospitals (i.e., requirement to conduct community health needs assessments and develop implementation strategies). Across sites, partners acknowledged the role of the ACA in supporting movement towards value-based reimbursement and the assumption of financial risk for keeping people healthy and out of acute care settings as a key motivating factor for at provider partners.

The most direct influence of state public policy cited was the reform process in Oregon to establish Coordinated Care Organizations and the Regional Health Councils (**COHC**). An important element of the reform process noted by one **COHC** interviewee was the modernization of public health functions through cross-jurisdictional sharing of staffing and responsibilities. **THT** cited state legislation to establish four regional health hubs, which included funding, access to data, and the development of a working relationship with state agencies. The importance of engagement in the public policy arena is reflected in staffing for **THT** that includes a Senior Director of Policy and Strategy. On a more indirect level, one informant for **HR** cited action by county agencies to take advantage of changes in state regulations around prescribing practices with opioids with the launch of their SafeRX program. Local policy development cited by partnerships included work on fair housing policies (**PP4H and CCG**), changes in zoning and adjusting the allocation of community development block grant dollars (**HR**) has been helpful in efforts to address homelessness.

Interviewees more often cited the *lack* of action or inflexibility in state policy as impediments to progress. One key informant noted that "unspoken rules are more prevalent that those in statute," and there is a need for state agencies to remember that different jurisdictions are unique, and flexibility is needed to take advantage of different strengths and dynamics. **PP4H** cited a need for greater parity in services within and external to municipal boundaries, and lack of innovation in the SNAP program, suggesting the replacement of the individual means-based program with a community wide approach that supports local agricultural producers. Both **HR** and **COHC** informants called for states to thoughtfully consider the difference between urban and rural counties, providing flexibility to determine how best to use available funds. **HR** recently had to defer on an application to fund innovations in behavioral health services because the requirements were too cumbersome, and timelines were unrealistic. A **COHC** informant noted that there are many community-based organizations in the region, and more explicit focus and support is needed to better align and pursue economies of scale.

MiHIA informants represented their partnership as a product of initiative and innovation by industry stakeholders at the regional level in the absence of state action. One **MiHIA** key informant lamented that the State of Michigan didn't seize the opportunity to secure State Innovation Grant (SIM) funding, which impeded efforts to advance innovations in areas such as trauma informed care, school-based health, and addressing the opioids epidemic. According to one key informant, advocacy for state policies has not been a priority to date, in part because partners do not see a level of interest or action in the legislature, and where there is action, a tendency to focus primarily on large urban centers.

Impact if Partnership Ends

As a final overarching question, key informants were asked to hypothesize what would be the most significant impact in their communities if their partnership were to end.

Some cited the loss of a "center of gravity" in the community, a loss of structure to ensure community voice in planning and actions, contributing to an erosion in trust of the institutions, increased burnout among providers, and hopelessness among residents, given considerable investment of time and purpose. Others predicted a return to competitive dynamics among providers and agencies, the "loss of linear progress," leading a return to small scale programs and siloed activities, rather than alignment and scaling of efforts with much greater potential to produce substantial and lasting impacts. At least one informant suggested that an institutional partner may attempt to compensate for the loss of the formalized structure by serving as a convenor, but would find it difficult to resist the tendency to become the "gorilla in the room."

Informants for **CCG** emphasized the distributed leadership that has emerged from deep engagement of residents, and the most significant loss would be the amplification of community voices that is gained through coming together. This amplification and reinforcement of messaging by many stakeholders has been key to securing resources that would not otherwise come to these communities. Both **THT** and **MiHIA** informants indicated that the loss of the partnership would deprive organizations and communities the opportunity to build consensus around important public health issues and would contribute to a negative view of collaboration and minimize the value of having an independent "backbone" organization.

All respondents viewed the loss of their partnership as unlikely, given returns on collaborative efforts to date. The sense of familiarity among partners and aspirations, as well as the emergence of common goals made it difficult to imagine partners walking away from the table. The partnerships have achieved high mutual respect through dedicated effort. As described by one informant:

> *"I've come to understand we are more alike than we are different in our mindsets when people work together. There was a time when I would not have talked. It took time to learn that I could use my voice to weigh into conversations. Once I understood that, they couldn't shut me up and they didn't want to. There was little old me, making a difference."*

IV. Partnership Leader Findings

Partnership leaders were asked targeted questions focusing on their role, the roles and contributions of community members, and their success to date in facilitating the sharing and use of data to support the alignment of efforts and validation of progress.

Role of the Partnership Convenor

Partner leaders were asked to describe the roles of their organizations in advancing the goals and objectives of their partnership. One leader used the visual of a winding road as a metaphor, assisting partners in navigating twists and turns, identifying "lanes" where there is exclusive use and others where there is overlap, and leveraging different strengths that help to achieve objectives. All represented their organization in one way or another as the "backbone" for the partnership, ensuring alignment of goals, fidelity of implementation, funding, and sustainability.

Roles include translating diverse perspectives into a common vision, which includes drawing out and directly addressing what may be unstated to minimize the potential for future dissention. Other roles include mobilizing partners, identifying and overcoming barriers, and monitoring progress. Some lamented the lack of appreciation for the resources needed to maintain a sufficient partnership infrastructure, noting that providing neutral facilitation is essential, but insufficient. One noted that to effectively monitor progress, there is a need for people with analytic expertise *and* the ability to make it understandable to diverse stakeholders.

Roles and Contributions of Community Members

Partnerships with larger geographic scale acknowledged challenges to community member engagement. In some cases, community members are paid stipends for their participation, and effort is made to encourage candor and assertiveness in raising issues with institutional leaders. **MiHIA** and **HR** are reaching out to racial and cultural organizations to expand community engagement. **COHC** benefits from strong State support for community engagement and has 250 to 300 community volunteers that take part in six workgroups that meet monthly. **THT** is in the process of creating a separate a community advisory council to have a better voice, active participation, stipends for participation and childcare. **PP4H** has bylaws that require it to be a community led coalition. Each track of work ensures parity between an institutional partner and a community resident partner and they are included on the Executive Board. For **CCG**, community members provide the grounding for all activities; nothing moves forward w/o the buy in, support and trust of the residents.

Data Sharing

HR is in the early phases of data sharing, with the two provider partners sharing some ED utilization data in a special committee. **MiHIA** manages a dashboard with data from existing sources, but not

from healthcare partners. The State HIE collects data, and they work with them to conduct targeted analyses after the health care partners authorize how data will be used. There is an interest in expanding to conduct their own analyses, and they are in the early stages of conversations with healthcare partners.

THT partners invested in the technology and expertise to share data through one of six health information exchanges in the state, but also recognized and invested in building data interpretation skills of community partners. They created a tool on how to share data with each other call, 'Let Me Tell You', which helps to balance power dynamics around evaluation. The capacity building went beyond interpreting end results but involved community partners in the evaluation design process.

COHC has access to utilization data and is creating a community dashboard. They are also making the regional health assessment digital so those who contributed financially to the assessment can have direct access to the data. The director meets with clinical managers on a bimonthly basis to review progress against quality incentive metrics. This is important because the quality incentive money generates returns to the community and is redistributed to those who performed well.

An important early form of data collection for **CCG** was documentation of high asthma rates and acuity at the Avalon Trace housing complex, helping to make the case for enforcement of existing ordinances. At the same time, there are challenges with securing utilization data in the absence of a research partner. They are in the process of collecting qualitative data on the impacts of neighborhood improvements such as sidewalks and park on issues such as social isolation.

V. Healthcare Leader Findings

Healthcare leaders were asked targeted questions to highlight the degree to which their engagement is part of an internal systems change process consistent with the larger movement towards value-based reimbursement, as well as changes in their working relationships with related sectors.

Primary Objectives and a "Theory of Change"

Health care leader key informants were asked to identify the primary objectives for their organization in their participation in the partnership, and what they view as their "theory of change," described as changes they envision as organizational outcomes associated with their participation.

One informant expressed the need for a "healthy well-being" coalition in every community; one that invests in leadership development, community empowerment, healthy lifestyles, and well-being policies. She gave particular emphasis to ongoing investment in the infrastructure of the coalition; that short-term initiatives and grants are unlikely to produce long term change.

In at least one case, a key informant acknowledged a gap between representatives engaged and the senior leadership in understanding the importance of the work and how it will help achieve their organizational strategic objectives. The opportunity to see the partnership as an extension of the healthcare system remains an unrealized objective to date and making these connections has been further complicated by COVID-19.

Revenue losses have created an imperative to increase volume:

> *"We did exactly what society needed us to do between mid-March and mid-May. And it is devastated our business. We get paid to do the wrong things in the current system of payment and the only way out of it is to do more of the wrong things."*

Another health care informant noted that their hospital "has a long way to go to take the social determinants of health seriously," and that much of their progress is driven more by investments made by the larger system than through the commitment of local hospital leadership. To date, the relationship between the partnership and transformation of the health care system is limited at best.

One health care key informant shared that their system sees upstream investments as one way to get to the prevention of unnecessary, low value care and prevention of human suffering. They have a strong ACO which is "influential in flipping the investment" but it is focused primarily on care management. Their theory of change is to pick upstream investments with measurable outcomes to build internal skills that can be applied to other conditions. This key informant described the partnership work as transformational on the professional level:

> *"This is the most authentically led work that I've ever been a part of, where the most beautiful stuff is, where I learn the most. I get pushed to think about my blind spot, mistakes I've made in other partnerships. Also, what is possible when this is authentic? I feel valued in this work."*

One health care informant acknowledged that the services provided by health care organization partners represent only 10-20% of what is needed to improve health and sees community-based organizations as "critical tools" in addressing the social determinants of health. At the same time, the informant did not see a role for the partnership in helping to rationalize the care delivered across competing systems in the region, stating that:

> *"If the collaborative starts to try to direct healthcare systems on how they should do business, this becomes a bigger concern. I think the regional collaborative needs to be careful not to step on the toes of the organizations that are supporting it. If it does, there has to be very strong reason to do so."*

These statements highlight the challenges faced by partnerships involving competing hospitals, some which may be less inclined to consider deeper, transformational change as a goal for their organization. The power and resource differential between these large organizations and the spectrum of community-based organizations is difficult to resolve if a clear commitment to consider fundamental change is not made by the senior leadership of these organizations.

Movement Towards Value-Based Payment

Healthcare key informants were asked to describe whether and how their participation in the partnership supports movement towards value-based payment (VBP).

The **HR** health care key informant noted that Lake County has one of the largest VBP contracts, and there is an imperative to increasingly link the work of collaboratives to health-related outcomes. She emphasized, however, that it will be important to find better ways to tell the story. **THT**'s health care key informant indicated that movement in this direction is hampered by the persistence of fee for service as the dominant system of payment in New Jersey. While moving to VBP is a goal, most health care providers are engaged in work to address the social determinants of health because their mission indicates a commitment to improve health and well-being.

PP4H is building relationships with clinical leaders of their health care institutional partner. The imperative to address COVID has been beneficial to build these links, supporting regular discussions that would not have otherwise taken place. For **CCG**, half of Cone Health's revenue is in a risk-based model and they are interested in expanding. As noted by the key informant:

> *"A big part of institutional support is figuring out how do the work without anyone saying you can't."*

While North Carolina is one of the few remaining states that have not implemented the Medicaid expansion, it has been a breakthrough to get Cone to think about people who don't have a payor are worth a strategic investment of resources.

MiHIA focuses more broadly on regional initiatives in topic areas such as opioid reduction, diabetes prevention, ACEs, pregnancy, BH and substance use, establishing broad common goals while

competing systems do their own utilization analysis that help document improving organizational performance in risk-based arrangements.

COHC is a positive outlier among the six partnerships, operating in a full-risk capitated environment. There is a 12.5% risk withhold this year on the hospital capitation payment which St. Charles Health System can only earn 50% of back and the other 50% of the withhold goes to independent providers, medical groups, and **COHC**.

Partnership Objectives and Health Care Engagement

Health care key informants were asked if they could identify objectives for the partnership, that if achieved, would trigger expanded engagement. The intent was to determine the degree to which engagement in the partnership transcended a "project mentality" focusing on achievement of objectives with patient populations or communities to include what changes are needed for health care organizations to thrive in a VBP environment.

Some key informants identified a need for deeper work to clarify governance and decision making, as well as communicating accomplishments in the broader community. For some, there is a balancing act in movement towards an investment strategy and caution about imposing their measurement framework. While health systems have money and expertise to develop sophisticated metrics, there is a need for sensitivity to what may be applicable to the broader partnership. Similar sensitivities were identified in **MiHIA**, which has benefited from exposure to different frameworks to build population health capacity but competing health care partners have not reached consensus on a single path.

Some key informants expressed a concern about being broad and shallow in their approach, and a desire to stay data driven, improve processes, produce quality programs, and identify policies that contribute to sustainability. The additional scrutiny requires a renewed focus on metrics that justify continued investment.

Roles, Payment Structures, and ROI

Health care key informants were asked to share their vision of what may be emerging as optimal relationships between health care and related sector agencies in terms of roles, payment structures, and what may be the best approach to allocating returns on investment.

One informant pointed to growing awareness of the need to be more intentional in their engagement with public health and acknowledge approaches that have not been efficient nor effective. She pointed to a need to better focus on alignment and focus of resources in rural communities, and to eliminate major silos in the social service sector. Integration of physical and behavioral health is a top priority, particularly in the wake of the pandemic. In general, there is an ongoing conversation needed to build and relationships.

Informants called for continuing dialogue across sectors and partners to determine how best to configure and allocate responsibilities for services among those who are best positioned to provide them in the most cost-effective manner. Increasing attention is needed to the diversification of revenue streams, bringing contributors outside the physical health arena to reduce the demand for preventable physical health utilization.

Securing support for related sectors is a challenge for health care partners, and their leads in these partnerships devote considerable attention to building knowledge and understanding of potential returns on investment. At least in one site, that involves providing core support for organizations focusing on housing and making the case by linking social returns on investment such as reduced expenditures for law enforcement and housing evictions to health data. While these are important efforts, it was noted that the lack of definitive outcomes, in many cases, is a reflection of the learning curve in determining the right metrics in more comprehensive interventions that highlight the value of investment in improving quality of life.

At least one health care key informant pointed to a need for clarity of roles and leveraging the expertise of different partners. In this sense, engagement is more about learning more about the potential contributions of each partner and finding a way to provide the support that is needed for them to be successful. Health care organizations may choose not to build internal public health expertise but find ways to better support expanded capacity of those organizations through the partnership.

Implications of Partnership Structure

Health care informants were asked to share their view of the advantages and disadvantages of having an independent entity to facilitate, monitor, and in some areas, make decisions on behalf of partners.

One health care key informant indicated that if there isn't a backbone organization at the beginning, it's difficult to bring sufficient focus to the work. "Loads of people want to do this work but it's done at night or as a side job because there is no time or resource to do the work." She expressed the need for role clarification and an authentic motivation of love and empathy to break down barriers.

Key informants also acknowledged the fragility of their partnership structure, both in terms of funding security and their ability to drive the process given tendencies among large health care providers to "medicalize" strategies to address the social determinants of health. One informant emphasized the importance of an independent point of view and a strong commitment to balance and mediate when there is friction among partners. While informants had difficulty imagining their partnerships ending, their comments reflected a recognition that maintaining healthy relationships requires vigilance.

VI. Community Leader Findings

Community leader key informants were asked to share how community member experiences and perspectives are reflected in the membership and actions taken by their partnership, and to share examples where community input has produced results. In the examination of these issues, a distinction is made between professionals who may live in communities of focus and represent community-based organizations, healthcare, and related sector institutions, and community residents who are served by these organizations and institutions.

Community Resident Engagement

One key informant lamented the limited engagement of residents, that the dialogue would benefit from the participation of ordinary people who know what it is like to deal with the local health system. Another expressed appreciation that partners at the table represent the community and the associated needs, but there is a need for clients who have an equal role and status in meetings. Two informants emphasized the important role of the faith community in bringing members to the table that represent diverse life experiences. Multiple informants emphasized the work needed to ensure a focus on equity, race, education, and social status, and the importance of partners from multiple backgrounds asserting leadership at different times.

To varying degrees, each of the six partnerships secure at least some of their community input through engagement of frontline and grassroots organizations. One community leader described her work with institutional leaders to open their minds to community member engagement, emphasizing the importance of listening to their stories.

Actions Driven by Community Resident Input

Patient safety has emerged as a priority for **MiHIA** through strong advocacy by a community member on their board, and it is reflected as a key element in their Thrive initiative. Data collected and presented continues to highlight challenges and limited accountability to date in this arena. For **THT**, engagement of community residents yielded the identification of SIDS as a significant concern and responding to this was an important way to build trust and engagement. For **CCG**, the partnership successfully secured support for sidewalks to provide residents with safer options to walk, since many do not have access to cars, but residents also called for better bus routes that get them to key community resources. As noted by one resident:

> *"We don't need a safer place to walk. We have paths and we walk. What we need is better transportation, bus routes. The buses pick a person up and drops us off four blocks from the medical center. And I'm sick and now I have to walk."*

Overcoming Obstacles to Participation

Community leader key informants identified a range of obstacles to ongoing participation on partnership boards and committees, from the time commitment for younger adults who are parents, to the lack of transportation. One informant noted a shift in focus to grandparents as an important source of practical knowledge and wisdom; another indicated dialogue to support the establishment and support of an independent community advocacy group. While there is agreement that stipends and childcare are important and are pursued to varying degrees, at least one informant noted that public sector agencies have “red tape” that makes it difficult to pay stipends.

While acknowledging the important contributions of community-based organizations, key informants emphasized the importance of direct lay community member engagement. As stated by one interviewee:

> *“As long as we are speaking on behalf of a person, the response is still an interpretation of what the person said. Services received vs. services given are different experiences. A person on the board may have experienced it, but they are surely on the other side of it. Everyone has to hear the struggle from the person who is having the struggle.”*

One key informant addressed the importance of adjusting meeting times to accommodate local residents, working closely with the faith community to spread the word, and in many cases, serve as the convenor for residents. Another pointed to the importance of providing training and coaching to support powerful expression of community member knowledge and experience.

While building trust across competing organizations is critically important, key informants emphasized the importance of building trust with community members, as well. As stated by one key informant:

> *"People have to get the sense that you care about them. After showing up consistently, people will begin to trust you. If you have skin in the game, people will begin to feel respected; that this is not just a ‘once and done’ project. This organization cares for us. We will do this work knowing we are in this together. It’s not a sentimental feeling, but a practical conclusion.”*

Some of the partnerships have significant programmatic elements to provide job training to community residents. For **CCG**, their approach is to encourage local businesses to look to their organization to recruit community residents as a direct path to strengthen the community.

VII. Related Sector Findings

Related sector leaders were asked to describe how their participation in these cross-sector partnerships informed and related to their own systems change process, including evolving organizational roles and ensuring the engagement of community residents.

Primary Objectives and "Theory of Change"

COVID-19 was cited by all related sector key informants as creating an imperative for fundamental change, highlighting both profound inequities and the daily challenges to bandwidth at the individual, departmental, and agency levels. There is urgency to break down silos to get resources into communities in a timely manner.

For **MiHIA**, a key related sector partner is Central Michigan University, and the partnership has created an array of new opportunities to build population and public health capacity in the region. CMU has the youngest medical school in the state, and the relationship with **MiHIA** has contributed substantially to its establishment and growth. CMU has taken new steps to expand their education pipeline across disciplines. In the health sector, they shifted their psychiatry residency in recent years in response to a dire need for services in the region and state. It is now community-based, where residents and students work in FQHCs and other community-based organizations.

In Oregon, **COHC** has worked with United Way to help move towards a more strategic approach to serving communities, reflecting the fact that providing small grants to social service agencies over the last 75 years has not 'moved the needle.' There are so many more organizations in communities now that there is question about UW's relevancy. Partnering with **COHC** has helped explore movement towards 'collective impact' models.

In the western suburbs of Chicago, the Cook County Department of Health replicating the co-design process implemented as part of **PP4H** and integrating principles of quality improvement to ensure ongoing monitoring and refinement of efforts in other communities. The DOH representative to **PP4H** noted that co-design has been a new approach, adjusting and pivoting when necessary to apply early lessons.

For **HR**, experience to date has helped illuminate a theory of change for the public health agency. They worked with partners to write a plan and assembled a team from partners to deploy for mobile testing. The partnership has demonstrated the capacity to be nimble, adjusting their plan as the state shifted their strategy. It is proof of the effectiveness of their partnership.

New Roles for Related Sectors

For **HR**, as the state of California moves increasingly towards managed care, there will be a need for increasing interface with local public health agencies. This presents opportunities to help break down siloes, align, and focus services where health inequities are concentrated - and to provide an evidence base to validate progress. Among the most significant challenges in assuming new roles,

however, is the lack of flexibility among state agencies in the allocation of funding and associated requirements. Grants are often too small to fund a new position, present too much additional burden for an existing staff member, , or the salary they are able to offer will not attract anyone.

The COVID pandemic has also spurred new thinking at CMU about their role with **MiHIA** in communities, with new efforts to reduce the impact of trauma and a robust approach to civic engagement. The expanded use of telehealth during COVID has also contributed to new thinking about building interdisciplinary capacity. The social determinants of health are being taught across the educational spectrum and the university sees itself as a key strategic player in the community to build language and culture for that supports this work.

The public health agencies partnering with **COHC** in central Oregon are among of the first to hire high school students part time in social messaging on key issues such as tobacco. They help get messages out in school and speak with county commissioners. For many, it is the entry point to consider health careers. The public health department also runs the school-based health center.

As a partner in **COHC**, the United Way is UW is a small organization that struggles with a reduction in revenue. Total revenue dropped 17% during the last recession and 12 years later they are still raising less money than they did in 2008. Securing staffing with competent professionals is a constant challenge. As noted by the informant:

> *"It requires people to have faith that we can do better with their money than they can, and over time we have lost that credibility."*

For the **Trenton Health Team**, a new role for all partners is expanding the availability of affordable housing in the community. Among the systemic challenges is that individuals in supportive housing can't secure stable employment because when their income exceeds a certain level their housing becomes at risk. Individuals are faced with difficult choices.

> *"Do I move ahead with life goals at the risk of my housing? An impossible choice."*

Despite limited staffing capacity, the Cook County Department of Health is applying lessons from their experience with **PP4H** to build capacity with other community groups, including educating people on how to use data in a way that does not just tell communities about their bad outcomes, but also highlights assets, or “bright spots” and how they can be leveraged and build momentum.

Community Resident Engagement

Organizations and agencies in related sectors such as public health, social services, and community development often have in depth working relationships with diverse community stakeholders, not only through the provision of services, but to help inform assessments and to act on priority issues. Given these connections, they provide a unique perspective on whether the current partnerships reflect the optimal form of engagement.

In general, related sector key informants indicated that community voices are expressed through a variety of committees, as well as CHNA and public health accreditation processes, but more work is needed to further amplify community voice through regular input, meaningful listening, and ongoing engagement. For regional partnerships, community voice is expressed primarily through organizational representatives who are champions, but they are still interpreting issues on behalf of residents.

As partnerships take move into local and state policy issues, there is an imperative to build common knowledge among residents of legislative, licensing, and regulatory dynamics and their implications for life on the ground. For some, taking on issues around students in the K-12 arena (e.g., graduation rates, attendance, ACES, trauma-focused services) is a point where they come together.

Related sector agencies see themselves as conveners and neutral brokers, and increasingly recognize the need to strategically focus on fewer issues. Informants lauded strong support for diversity, equity, and inclusion, but emphasized the need for more efforts to bring under-represented groups to the table.

One informant noted that the voices of some community leaders dominate at the expense of others, undermining the potential for a deeper understanding of issues.

Just as some have emphasized the importance of training for community residents in these partnerships, one key informant emphasized that a similar process should be considered for institutional representatives. Training for professional partners ranges from providing background information about the community to encouragement to “leave the suit and tie at home” to reduce the potential for intimidation that creates barriers to open communication. In the absence of explicit encouragement to share local knowledge and respect its value, resident participants can become passive, disenchanted, and ultimately disengage.

VIII. Closing Reflections: Why is *This Work* Important?

At the close of the interviews, key informants were asked to describe what they viewed as the most important message they would like to share with other colleagues who are engaged in intersectoral community partnerships. The power and clarity of their responses compels us to directly share their responses, lifting their voices just as we seek to do with the residents of our communities. With minimal context setting, here are their responses.

Alignment and Institutional Transformation

Informants focused on the goal of their partnerships to help sector partners better align efforts across related sectors, and to muster the courage to continue their work on the path of institutional transformation…

"It's a learning curve. What helped at the very beginning was to look for a framework. The AHRQ framework really helped. It required people from their community to think together, and they met peers across the country. Next, the Institute for Healthcare Improvement helped build our framework and process, to determine our destination. We became stronger and more disciplined in our efforts. The recent addition of Thrive is helping to step back, take a breath, and look at how to apply learning and design a new approach." ***(MiHIA)***

"We have to make the health system we have work as well as we can. There is so much waste, inefficiency, duplication, ineffectiveness in how we do things. If we can get our ecosystem to work to the maximum effectiveness and efficiency, we can do much with the resources we have. All the systems around health don't work well together but everyone working in them wants them to work better. They need each other. We are building interdependence in the system so the problems and the solutions can find each other faster. And that is gratifying." ***(THT)***

"Get your head out of the sand. I tell myself that. I think we all need to do that. Especially in work where we're all well-meaning, where we all think highly of our own intentions, but we're spread thin. We all have blinders on so we need to pick our heads up try to look across sectors, understand each other, appreciate each other, the better we do and the bigger impact we can all make. It's hard to do without being intentional about it." ***(PP4H)***

"Your partners are not going to be perfect. And neither are you. Instead of quitting and taking your toys home, use it as an opportunity to learn a way to not do it. But it is still a learning opportunity. You have to be committed to being learners for the entire life of the collaborative. It's not like we learned right away. We had to learn how to and not how to do this work. And stay present for it." ***(HR)***

"The only way that we will change healthcare is to do it together. The patients are not a physical thing or a mental thing. We're the whole thing - food, housing - so we have to have a system of care which addresses this hierarchy of needs and not a single one of us can solve it so we need to find a way to solve it in a coordinated fashion. It's just too broken." ***(COHC)***

Racism and Equity

As our country gradually comes to grips with the many ways in which our policies and practices have perpetuated the oppression of so many, key informants reflected on ways in which their partnerships are charting a more inclusive and supportive path to the future.

"We must call out the elephant in the room. I call it structural racism for us in our community. The power is around race and class. If you call out the root cause at the beginning, you can solve so many issues. Our systems don't work, not because there is a lack of money but because we have decided Black people aren't really people. Just statistics and a problem so we're not going to invest time, effort and resources into those communities. ***(PP4H)***

"In order to address systemic racism, community residents need to be imbedded into design and implementation – it will save you time in the end. Let the residents voice their thoughts, reflect their culture, build that thinking into the entire process. People of color must be at the table when you're designing the things that impact their population." ***(CCG)***

"I don't want in 10-20 years, or when I decide to have children, to have my child drive from one side of town to the other to see a different world or a different life. I don't want children growing up conditioned to certain environments. America as a country is so capable providing that future for children to not have to see that type of world. It's not so dreamy to ask for neighborhoods and communities to have the same resources, to be just as beautiful as the one on the west side of town." ***(CCG)***

Building Trust

The third theme in key informant reflections about intersectoral partnerships is building trust; across competing health care organizations, across sectors, and the communities they serve.

"The partnership has had a positive impact on the level of trust in the health system. The public typically doesn't get to ask a question directly of a CEO, to see him or her directly. So the collaborative is breaking down barriers, opening up communication. You can learn something every single day and have the ability improve every day." ***(HR)***

*"Trust and building relationships is what makes the difference. When that is established there is so much you can do. Then when things are hard and we don't have funding, we can still be there for each other. Only because we've built the relationships over time. Especially when dealing with communities that have felt used, abused, not appreciated. It's so important." **(PP4H)***

*This is a group that pushes each other, sees our differences, appreciates the different ways that when we're aligned in caring for that neighborhood, that the pieces we bring are extraordinarily valuable and useful. The authenticity and integrity that we're asked to have is challenging and exhilarating." **(CCG)***

*"Our secret sauce is nothing more than a true investment in relationships. Our director knows not only the names of members, but their families, as well. Board members have a familiarity that supports frequent communication and a shared interest in getting things done." **(HR)***

*The value of having one community health assessment and improvement plan that everyone can turn to for their own strategic thinking. On a more personal level recognizing that what people can do to help improve health and well-being is to be kind to one another. It had this profound effect on me, to see how this rolls up in so many ways." **(COHC)***

*"I want people to know and understand that when it comes to life challenges, imagine if it were you. Empathy for people is essential. If we have it, we would see each other so differently. We all have room to grow, all of us. We will all be challenged but let it not be because of the color of our skin, class, neighborhood or education. I have a heart and I work with people who have a heart for change." **(PP4H)***

IX. Discussion

The purpose of this study was to provide insights into cross-sector partnerships and factors that either *impede or accelerate* achievement of definitive goals and objectives. Our intent in interviewing four representatives, one each from health care, related sectors, communities, and the partnership "backbone" was to highlight ways in which these stakeholders see and interpret what is working, what are challenges, and what are lessons for others to consider.

As a qualitative inquiry, our intent is not to test or prove the relative power of one or more hypotheses. Rather, it is our hope that the perspectives and stories shared by these committed individuals will inform others as they travel similar paths. Some learnings may be more applicable or transferable to one context or community than others. There are, however, a few overarching reflections for consideration by others engaged in or considering the formation of an intersectoral partnership.

Scale matters – Regional initiatives offer significant potential to rationalize services within and across jurisdictional boundaries in a manner that makes optimal use of differential expertise with an eye towards achievement of economies of scale.

Competitive dynamics die hard – Building a spirit of collaboration among competing health care providers and payors is among the more significant obstacles to building an evidence base through data sharing and leveraging assets. In some cases, senior leaders may keep partnerships at arms' length, permitting second level leaders to participate, but drawing lines that limit the impact that comes with genuine collaboration.

Funding stability – The historically based and geographically concentrated inequities addressed by these partnerships are not easily eliminated, and usually not within the parameters of the typical 2-3 year grant period. As such, establishing a stable source of funding for a "backbone" organization is critically important, as demonstrated with the establishment of regional health councils in Oregon.

Community resident engagement – While there are many obstacles to community resident engagement, there is ample justification for making the effort at every geographic scale. As evidenced by the input shared by key informants, genuine engagement pays a range of dividends; from building political support and avoiding turnover with local elected officials (and producing returns on those investments) to active mobilization and support of interventions that are consistent with local resident priorities.

Policy Development – Most partnerships start with a focus on "doing" things on the ground, and less attention is given to how gains made can be codified and sustained through policy development. Given limited resources in both private and public philanthropy, there is rarely sufficient support on the front end to develop a comprehensive strategy tied to a theory of change for institutions, and the infrastructure to manage the process. As a result, many of these partnerships lack the connections, resources, expertise, and leverage to engage state government agencies in a planning process that links innovation to policy development if it is not embedded at the beginning.

Appendix

Partnership Profiles

Proviso Partners for Health (https://www.provisopartners.com/) describes itself as "a community-driven, cross-sector coalition promoting community health, health equity, and transformational systems change in the Proviso communities of Maywood, Bellwood, Broadview, and Melrose Park" in Cook County west of Chicago. It began as an organic, community resident focus on a community garden in the western suburbs of Chicago. It expanded in 2014 with the entry of the Cook County Public Health Agency, which saw an opportunity to engage the community on the issue of obesity and diabetes prevention.

Population Type	Scale	Race/Ethnicity Culture	Policy Dynamics	Geography	Current/Former Initiative
Large urban/suburban	Four communities; Maywood, Bellwood, Broadview, Melrose Park	Melrose Park 70% Latino; Broadview 74% AA; Bellwood & Maywood 82% AA.	Medicaid expansion state	Illinois Midwest	SCALE / 100 Million Healthier Lives

Partners include, but are not limited to Loyola University Health System, Loyola University Chicago Stritch School of Medicine, Loyola University Chicago Marcella Niehoff School of Nursing, Public Health Institute of Metropolitan Chicago, Respiratory Health Association, Housing Helpers, Consortium to Lower Obesity in Chicago Children, Proviso Township Youth Services, Coalition for Spiritual and Public Leadership, Proviso School Districts 89 and 209, and more than a dozen other community and social service agencies and businesses. There are six hubs including: Economic Justice and Community Leadership Academy; Food Justice; Elementary School Wellness; High School Wellness; Community Wellness Hub; and Tobacco-Free Living. PP4H provides administrative and technical support to build on strengths and resources of the community through liaisons who are community members."

Hope Rising (http://www.hoperisinglc.org/#) "serves as a neutral convener to bring together leaders in our county to identify issues, develop innovative solutions, and implement agreed-upon actions with accountability and measurable outcomes. Hope Rising acts to raise, manage and disburse funds. The partnership in Lake County, CA emerged through conversations among local stakeholders about poor health outcomes and indicators at the county level, driven in part by fragmentation of services, described as "silos within silos," and devastating wildfires in 2015 and 2018. Impetus for a formal partnership was provided by participation in the "Way to Wellville" initiative (https://www.wellville.net/), bringing external support and expertise, and funding by local Adventist Health facilities and the Partnership Health Plan. Lake County was also selected to participate in the California Accountable Communities for Health (CACHI) initiative.

Population Type	Scale	Race/Ethnicity Culture	Policy Dynamics	Geography	Current/Former Initiative
Rural	County	70% Caucasian, 20% Latino, 4% Native Am.	Medicaid expansion state	CA West	CACHI; Way to Wellville

The Governing Board and Leadership Team includes CEO-level executives and program directors and coordinators from health systems, Medicaid payer organizations, behavioral health organizations, criminal justice, education, elected officials, housing, long term care, payers, public health department, providers, philanthropy, county agencies, non-profit organizations, elected officials, workforce development and community members. On their website, they indicate that "we have partnered for many years on a wide variety of health improvement initiatives, and Hope Rising formalizes those partnerships in order to improve the health and wellness of Lake County." Hope Rising operates through four program areas, including health, economic development, education, and a healthy environment that were identified through a collaborative Community Health Needs Assessment. The four goals are health, economic development, education and healthy environment.

The Central Oregon Health Council (https://cohealthcouncil.org/) is a state sanctioned governing body to provide oversight for the Coordinated Care Organization (CCO) in Central Oregon, and describes is role as "facilitating beneficial partnerships, invest in community-driven projects, and foster trust and transparency in an otherwise competitive industry," with the overall goal to "create a healthier Central Oregon, not only for individuals insured through Medicaid, but for all residents. It was an outgrowth of a state health care transformation process that began in 2007. It was selected as a test site for Medicaid payment reform in 2009. The intent was to create the first Regional Health Alliance to allow Crook, Jefferson, and Deschutes Counties to partner on health care transformation. The board became the governing entity of the region's Coordinated Care Organization in 2012, and was renamed the Central Oregon Health Council in 2013. The COHC has helped to maintain the cross-jurisdictional relationship between counties. Among the state requirements for COHC is to conduct and publish a Regional Health Assessment (RHA) and a Regional Health Improvement Plan (RHIP) every four years.

Population Type	Scale	Race/Ethnicity Culture	Policy Dynamics	Geography	Current/Former Initiative
Urban & rural 233k	Regional; 7 counties	69-92% Caucasian	Medicaid expansion state	OR Northwest	Author of enabling legislation for CCOs

Collaborative Cottage Grove (https://www.collaborativecottagegrove.org/) is an outgrowth of leadership by the Greensboro Housing Coalition over a decade ago to advance a vision of improved health through a resident-driven process and commitment to health transformation, community development and racial justice. CCG offers the following as a Mission Statement and Values; "We are here to come together with and for the entire community. To educate and nourish our community members. To motivate, encourage positive events and programs that will benefit ALL who want to make a change for the better within the Cottage Grove neighborhood. Our Values Include: Community-Driven Communication, Dependable, Relationships, Perseverance, Grace, Integrity, and Inclusiveness." "CCG has a broad spectrum of partners including Cone Health, City of Greensboro, Greensboro Housing Coalition, Guilford County Department of Health, the Mustard Seed Clinic, and others." Cottage Grove neighborhood has a median income of $12,000; 40% of residents are uninsured, and over 80% of the community lives in rental properties, many of which are unsafe due to mold and other health hazards.

Impetus for the partnership (CCG) included participation in Purpose Built Communities (https://purposebuiltcommunities.org/) that sees the fundamental linkages between neighborhood revitalization and health. In 2012, the city of Greensboro, NC secured a grant from Blue Cross Blue Shield Foundation of North Carolina to provide consultation about sustainable neighborhoods, and the Greensboro Housing Coalition, Mustard Seed Community Health, New Hope Community Development Group and Cottage Grove Initiative were chosen to be the recipients. A core objective was to build trust, recognizing that "so many people have brought ideas and promises, and so many have not been fulfilled." With a successful application to secure funding in the second round of the Build Health Challenge (https://buildhealthchallenge.org/), CCG engaged Cone Health as the major provider of health care services and added a focus on pediatric asthma. This led to engagement of local elected officials to support a more wholistic approach to community health improvement and revitalization.

Population Type	Scale	Race/Ethnicity Culture	Policy Dynamics	Geography	Current/Former Initiative
Urban/suburban neighborhood	Community	40% AA, 7% Latino	Non-Medicaid expansion state	NC Southeast	BUILD Health Challenge 2.0, Invest Health

The **Trenton Health Team** (https://trentonhealthteam.org/) describes itself as "a community health care collaborative dedicated to improving access to quality healthcare for city residents." Bringing together health care providers, the Henry J. Austin Health Center (local FQHC), and the City of Trenton Department of Health and Human Services, the focus has expanded over years to include a focus on the social determinants of health with a health equity lens in a municipal frame.

Their website indicates that "We believe that by collaborating we can actually drive down costs while providing significantly better, more comprehensive and effective care. THT is committed to including feedback from community members and patients in decisions about how we allocate resources and design programs. We work with community and healthcare partners on priorities identified by our community. THT was launched by Mayor Palmer in 2006. THT is one of New Jersey's first Regional Health Hubs, now with 40 employees."

Impetus for THT was the departure of Mercer Medical Center (part of Capital Health) from Trenton and advocacy in the community for an organization who would preserve access to health services. As part of a required state Certificate of Need (CON) process, the two remaining acute care hospitals came together with the local FQHC and the city health department and THT was established in 2010. THT serves as a structural hub, a place for system to align data analytics as well as a community think tank to act on identified priorities that are informed by the data.

Population Type	Scale	Race/Ethnicity Culture	Policy Dynamics	Geography	Current/Former Initiative
Med.urban (85k) in NYC SMSA	Municipal 6 zip codes	52% AA, 25% White, 33.7% Latinx	Medicaid expansion	NJ Northeast	Build Health Challenge

The **Michigan Health Improvement Alliance (MiHIA)** (https://mihia.org/) describes itself as "a formal, multi-stakeholder, community collaboration working to achieve a community of health excellence for the 14-county region it serves. It is based on a core belief that solutions to the state's health and health care problems can be found and designed at a regional level, accelerating regional competitive advantage and sustainability." MiHIA is described as serving as "the convener for multiple parties, establishing shared goals and objectives, setting collective targets, or aligning business plans. In other cases, MiHIA evaluates processes to reduce redundancies, conducting environmental scans, or providing health data. MiHIA also seeks funding to bring resources to our area and facilitates or supports projects or initiatives that will impact better health and health care in our region."

Key factors driving the launch of **MiHIA** was the advancement of a vision for data collection and sharing at the state level, leadership provided by the Chief Health Officer of Dow Chemical, facilitation by colleagues at Central Michigan University, and willingness by the leadership of four health systems to reduce silos to better serve the diverse populations in central Michigan.

Population Type	Scale	Race/Ethnicity Culture	Policy Dynamics	Geography	Current/Former Initiative
Rural and small urban	Regional 14 Cos.	90% Caucasian, 20% AA	Medicaid expansion	MI Midwest	IHI Pathways to Pop Health; ReThink Health

References

[1] Wilson, RT, Troisi, CL and Gary-Webb, TL, April 5, 2020, “A deficit of more than 250,000 public health workers is no way to fight COVID 19,” STAT, Boston, MA.

[2] Vangen, Siv; Hayes, John Paul and Cornforth, Chris, 2015, “Governing cross-sector, inter-organizational collaborations,” Public Management Review, 17(9) pp. 1237–1260.

[3] Clarke, A and Crane, A, 2018, “Cross-Sector Partnerships for Systemic Change: Systematized Literature Review and Agenda for Further Research,” Journal of Business Ethics, Vol. 150, pp. 303-313.

[4] Kania, J and Kramer, M, Winter 2011, “Collective Impact,” Stanford Social Innovation Review, Stanford University, Palo Alto, CA, pp. 36-41.

[5] Wolf, T, et al, Winter 2016, “Collaborating for Equity and Justice: Moving Beyond Collective Impact,” Non-Profit Quarterly, pp. 42-53.

[6] Acedo, A, Oliveira, T, Naranjo-Zolotov, M, and Painho, M, “Place and City: Toward a Geography of Engagement,” Heliyon, Vol. 5, Issue 8, e02261, ISSN 2405-8440, https://doi.org/10.1016/j.heliyon.2019.e02261.

(http://www.sciencedirect.com/science/article/pii/S2405844019359213).

[7] Erickson, J, “Multi-Sector Partnerships Have the Potential to Transform Health, But Most Aren’t There Yet,” Health Affairs Blog, January 26, 2018, DOI:10.1377/hblog20180124.947710.