

ALIGNING SYSTEMS FOR HEALTH

Two Years of Learning

Georgia Health Policy Center



**ALIGNING SYSTEMS FOR HEALTH
TWO YEARS OF LEARNING**

GEORGIA HEALTH POLICY CENTER

Aligning Systems for Health: Two Years of Learning
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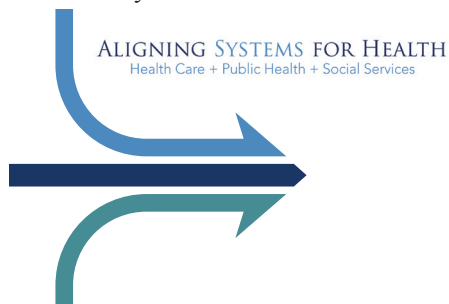
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WE DEDICATE THIS BOOK TO

Dr. Mark Redding, a tireless champion focused on improving health and equity.

Mark emailed a colleague, “I heard a quote recently that one only finds happiness in the service of others. ... I need to work harder in my life to find that happiness.”

By this measure, Mark was a blissful man. Mark was a devoted and beloved pediatrician, but he also lived the mission of aligning to meet the needs of individuals and communities through the Pathways Community HUB Institute, which he founded with his wife, Dr. Sarah Redding. Pathways Community HUBs have impacted thousands of individuals’ lives throughout the country using a whole-person approach for community care coordination.

Quite simply, Mark embodied the goals and boldest aspirations of aligning systems.

Mark will be missed as a friend and as a visionary force.

Mark Redding, M.D.
1960-2021

To create positive change that is sustainable and has lasting impacts, systems providing health care must put aside the silo mentality and align to be authentically successful. This book is the roadmap for health care providers seeking to create positive change that leads to generational impacts.

**—Donyel B. Barber,
Community-centered health director
Kintegra Health**

The case studies in this book give me hope that there is a way forward in how we reimagine and realign health systems so that they truly benefit the communities they serve. Community development is all about being an adaptive leader and I am particularly excited to see the focus on the adaptive factors that help align these systems so explicitly named. The challenges we face in health care and in community development are highly dynamic, increasingly complex, and disruptive—making resources like this one essential to our success.

**—Tiffany Manuel, Ph.D.,
President and CEO
TheCaseMade**

This book offers a timely assessment of what we know and what we still need to learn about aligning health and social systems. It goes far beyond the platitudes about why sectors should work together, by carefully examining the theories and the complex realities of multisector work. As such, it is a must-read for leaders in the practice community and for researchers in the health and social sciences.

**—Glen P. Mays, Ph.D., M.P.H.,
Systems for Action, Professor and chair,
Department of Health Systems, Management and Policy
Colorado School of Public Health**

*The Funders Network is committed to helping philanthropy understand and address environmental racism, economic inequality, and health disparities while engendering community-driven solutions. *Aligning Systems for Health: Two Years of Learning* provides funders and others with an evidenced-based roadmap for aligning systems to achieve health equity. The research and case studies show that effective cross-sector systems alignment must incorporate community voices, navigate power dynamics, and build trust. While not easy work, it is essential work if we are to eradicate the health disparities that plague our nation and improve health outcomes for all people.*

**—Patricia Smith,
President and CEO
The Funders Network**



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PREFACE

In 2020, the fragmented U.S. health and social services sectors began grappling with a devastating pandemic that has further accentuated historically rooted inequities in care delivery for the most vulnerable members of our society. The need for coordination and collaboration among these sectors has never been more clear.

The Aligning Systems for Health: Health Care + Public Health + Social Services initiative — now known simply as Aligning Systems for Health — is supported by the Robert Wood Johnson Foundation and focuses on identifying effective ways to align health care, public health, and social services to better meet the goals and needs of the people and communities they serve. This book encompasses the first two years of learning from this project.

In March 2019, Aligning Systems for Health set out to strengthen the evidence base around conditions that foster sector alignment and then translate the resulting insights to support communities, researchers, and decision-makers in their on-the-ground efforts aimed at aligning. The initiative is based at the Georgia Health Policy Center (GHPC) in the Andrew Young School of Policy Studies at Georgia State University.

At the start of the project, the Cross-Sector Alignment Theory of Change was conceptualized by the Robert Wood Johnson Foundation and then refined by GHPC. As the following discussion indicates, much of our book focuses on this theory of change, including the stories reported in the “Aligning in Action” and “Making Aligning Work” chapters, and feedback from the on-the-ground experiences of an emerging field of implementers, catalysts, researchers, and funders. The theory of change is also highlighted in the reports on and early learning from the project’s first rapid-cycle research grants. It is through all of these efforts — and reflections upon their lessons — that the theory of change transitioned to the Framework for Aligning Sectors, which is discussed in the book’s final chapter.

Chapter 1, “A Theory of Change for Aligning Health Care, Public Health, and Social Services in the Time of COVID-19,” is a reprint of a commentary that appeared in a July 2020 special issue of the *American Journal of Public Health*. In it, we describe the genesis of the theory of change, its major components, and how it adds to existing frameworks. We also cite examples

of cross-sector alignment nationwide. This work serves as a foundation for the learning that continues to unfold today.

Chapter 2, “What We Know,” provides a comprehensive literature review of existing knowledge about aligning’s core components: shared purpose, governance, shared data and measurement, and financing. Because aligning is an emerging concept and field, the review borrows heavily from research on health-related collaboration.

Chapter 3, “A Rapid Realist Review of Research Proposals,” provides insight into the process of launching the project’s first request for proposals in fall 2019. To better understand how researchers were interpreting and conceiving research projects around the emerging field of aligning, the GHPC team conducted a rapid realist review of 151 submitted proposal ideas. The realist method, which is one way to make sense of complex social interventions, focuses on how and why rather than on what, and asks the question: “What works, for whom, under what circumstance, and why?”

Chapter 4, “Aligning in Action,” offers a series of stories about on-the-ground efforts to align across sectors. Early in the project, people wanted specific examples of aligning. What does it look like? How does it differ from what we already know and have been doing for years? This chapter explores efforts throughout the United States that fit the definition of aligning. As these stories make clear, aligning is a journey — not a destination. In many cases, the examples do not have every element of aligning, but all are making great progress toward systems change that is built to last.

Chapter 5, “Making Aligning Work,” offers six briefs that highlight what was happening in aligning projects as they were unfolding. The research team conducted quarterly interviews with people from 10 organizations involved in or supporting various aligning efforts to find out what they were seeing. The interviews were semistructured and loosely followed a most-significant-change format. Following each set of interviews, the research team met internally to examine and begin to make sense of what it heard; the team then invited all of the interviewees to convene and make sense together. These briefs are the result of that cocreation process to elicit learning as it was happening.

Chapter 6, “Learning from Small Research Grants,” presents six research papers that share the results of our first rapid-cycle research awards. These six projects, conducted from 2019 to 2020, were the earliest external research efforts conducted as part of Aligning Systems for Health,

and they focused on discrete elements of the theory of change. We asked each project to share its methods, results, and implications for this volume; results from four additional rapid-cycle research awards — granted in spring 2020 and focusing specifically on COVID-19 — will appear in a future volume.

Finally, in Chapter 7, we preview the seven two-year research projects awarded in May 2019. Although results will not be definitively shared before late spring 2022, each project is contributing to a shared learning about aligning; in this chapter, we describe what each project hopes to learn. We then conclude with a discussion of an emerging tool — the Framework for Aligning Sectors. This tool, which builds on and replaces the theory of change, highlights the dynamism of the four core components and introduces four new adaptive factors — equity, trust, power dynamics, and community voices — that emerged from our learnings from the projects described in the book.



CHAPTER ONE

A Theory of Change for Aligning Health Care, Public Health, and Social Services in the Time of COVID-19*

Glenn M. Landers

Karen J. Minyard

Daniel Lanford

Hilary Heishman

With the nation now in the fight against the COVID-19 pandemic, the health care, public health, and social services sectors are rapidly adapting to new ways of working together, as resources are stretched and both workers and the public are more socially distant from one another. The coronavirus creates a new sense of urgency for how we design interactions among the three systems. Efforts to collaborate in new ways have generally been supported by one-off opportunities, whether positive or negative. One-time grant funding and pilot policies are examples of positive opportunities. Hurricane Katrina and the COVID-19 pandemic are examples of negative opportunities.

Based on their learning from years of their own grant making and that of others, the Robert Wood Johnson Foundation (RWJF) supports and learns from work that seeks to better align health care, public health, and social services. They envision alignment among systems that goes beyond one-time efforts, that better values the unique contributions of each sector, and that gives power and voice to community members. We describe a Cross-Sector Alignment Theory of Change that aligns with the foundation's vision of a Culture of Health that provides everyone in the United States a fair and just opportunity for health and well-being.¹

CROSS-SECTOR ALIGNMENT THEORY OF CHANGE

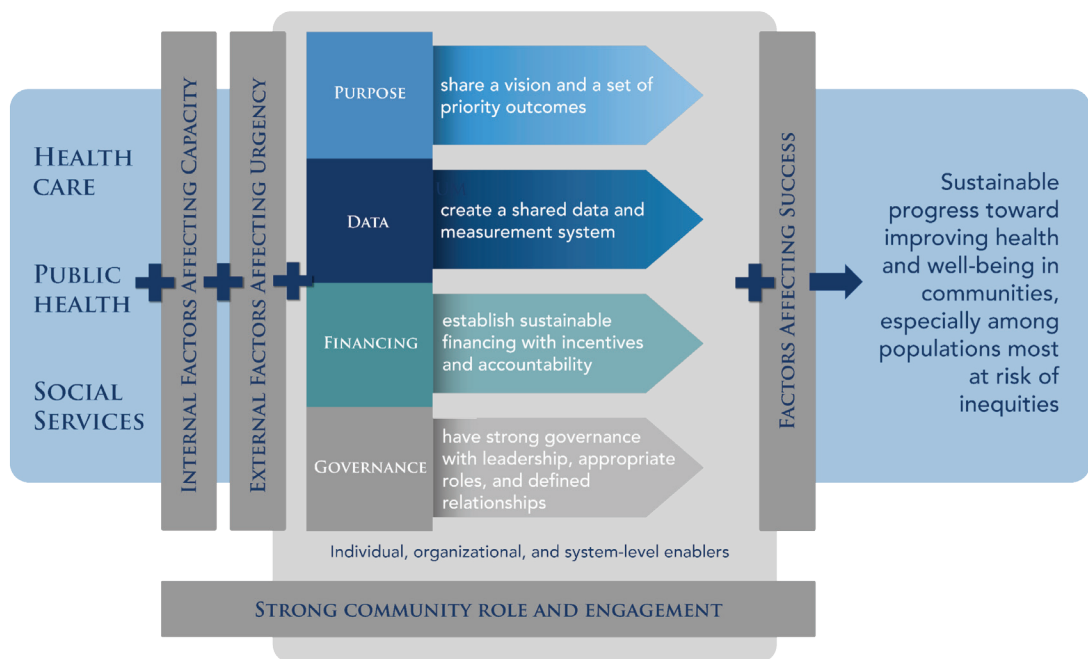
The Georgia Health Policy Center coordinates the national initiative Aligning Systems for Health: Health Care + Public Health + Social Services in partnership with RWJF. It focuses on learning about effective ways to align health care, public health, and social services to better address the goals and needs of the people and communities they serve.² Aligning Systems for Health is testing a Cross-Sector Alignment Theory of Change (Figure 1) that was created by RWJF from years of their own, and others', supported research and learning. The Georgia Health Policy Center, in its initial work, has adapted definitions of the three sectors from RWJF's complementary research program, Systems for Action.³ To sustain impact, cross-sector collaboratives should consider activating four core components of cross-sector alignment:

- Purpose — the focus of the cross-sector effort, informed by and supportive of community voice;

* Originally published in the *American Journal of Public Health*, 110 (Suppl. 2), July 2020, S179-S180. Reprinted with permission.

- Data — shared data that is meaningful to all partners and that enables sectors to effectively coordinate activities and measure shared progress;
- Financing — long-term financing that supports partnerships with incentives and accountability; and
- Governance — robust governance structures that include local representation and voice.

Figure 1. The Cross-Sector Alignment Theory of Change



Each of these core components may operate at the individual, organizational, or system level and should be driven by the voice and participation of community members. The impetus to align systems is shaped by external factors that might be considered drivers of cross-sector alignment: crises such as the COVID-19 pandemic; policy, statutory, and regulatory changes such as the movement toward value-based payment; state or federal grant initiatives; and public-private partnerships, among others. The core components are further affected by internal factors that shape organizational and system readiness, including backbone capabilities, financial management capabilities, leadership, a workforce with appropriate skills, and an information infrastructure.

Cross-sector alignment is moderated by factors such as individual and organizational trust, the ability and degree to which communities are engaged, the ability to hold each other accountable for meeting community members' goals and needs, and the availability of evidence to implement change.

As we build our understanding of cross-sector alignment, we have surfaced a number of observations about the theory of change from what is known about collaboration. Many (but not all) of the suggested elements require sometimes extensive resources. This means that in situations involving scarcity, less sophisticated alignment may be optimal. This does not mean that interested parties should avoid aligning. Rather, it suggests that cross-sector alignment may involve tough decisions and the establishment of priorities that will be optimal only in certain contexts. The complexity and potential for variation in collaborations and collaborative context suggest that cross-sector alignment will emerge in different ways and face different challenges. It may make sense to try to formally and explicitly make sense of these different paths so that individuals and organizations wishing to align are aware of potential entry points and have tools for identifying and addressing the most relevant challenges and opportunities.

The core components of cross-sector alignment overlap. In other words, they reinforce each other in a number of ways, both in real time and over time. Accordingly, they could be understood not only linearly but also cyclically. A shared purpose is not necessarily a primary purpose. There are many reasons to join health-oriented collaboratives, and each partner comes with a different set of priorities. While establishing shared purpose may be an important process, it may also be important to develop a means of managing the distinct and divergent priorities of the partners involved. Equity, a key component of cross-sector alignment outcomes, is closely linked to community voice. However, we have not yet fully elaborated best practices for prioritizing community voice.

EXAMPLES OF CROSS-SECTOR ALIGNMENT

RWJF and others have supported cross-sector alignment for several years, and its impact is beginning to be realized. The Accountable Health Communities Model, supported by the Centers

for Medicare and Medicaid Services, was launched to address the critical gap between clinical care and community services in the current health care delivery system. Early work has developed standardized screening for health-related social needs in clinical settings (<https://bit.ly/2AHjZje>). Washington state launched nine accountable communities of health that are supporting the Delivery System Reform Incentive Payment program's goals to build health system capacity and integrate physical and behavioral health services (<https://bit.ly/3dyNJgF>). Through a braided funding model, the state of Rhode Island directed more than \$10.4 million in public health funding to community-led health equity zones to address the social determinants of health and eliminate health disparities.⁴ Public and private partners are supporting the California Accountable Communities for Health Initiative to realize a more forward-looking approach to building a healthier California; this initiative is creating new ways to sustainably finance cross-sector work.⁵

CONCLUSIONS

The Cross-Sector Alignment Theory of Change builds on previous public health and social change models and focuses specifically on how health care, public health, and social services can better meet the goals and needs of the people and communities they serve in a way that is built to last. Like the spectrum of prevention model, the theory includes the roles of providers, coalitions, and networks; internal factors such as organizational practices; and external factors such as the roles of policy and legislation.⁶ Similar to the collective impact model, the theory highlights the role of purpose (common agenda) and shared data and measurement.⁷ The theory of change adds to these models by focusing on the well-being of individuals and communities and the roles of individual and community voices in determining desired outcomes. It challenges us to think beyond one-time, limited-term efforts.

The theory of change will continue to evolve as more evidence emerges from research and evaluation on aligning health care, public health, and social services. Creating sustainable cross-sector alignment may take generations, although the COVID-19 pandemic presents an unprecedented opportunity to rethink the future. The theory of change is a tool that can guide the work of individuals, organizations, and systems as they redesign that future.

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CHAPTER TWO

A Literature Review of Health-Oriented
Cross-Sector Collaboration Research

Daniel Lanford

Aliza Petiwala

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Eric Napierala

For at least the past decade, health care, public health, and social services organizations have experimented with collaboration to improve the health of their communities. Although progress has been made, the results fall short of expectations. According to the Cross-Sector Alignment Theory of Change, the practice of cross-sector collaboration must transform into a more powerful force involving aligning structures that are built to last, especially in the areas of shared purpose, governance, finance, and data. Additional factors are expected to enhance the power of cross-sector alignment, especially the full incorporation of community voice and the adoption of an equity lens. According to this theory of change, when all of these cross-sector alignment factors are in place, people and communities are more likely to get their needs met — particularly the needs for improved population health and health equity. To provide a research foundation for the transition from collaboration to alignment, we examine the health-oriented cross-sector collaboration literature to synthesize what existing research tells us about shared purpose, governance, finance, data, community voice, and equity. We discuss the results of our exploration here, including both descriptive and synthetic findings that emerge only when the literature is viewed as a whole. We conclude this chapter with 10 overarching observations to consider as we move forward.

BACKGROUND

Over the past decade, health-oriented cross-sector collaborations have become an increasingly important area of both research and practice. This movement is fueled by several factors, including:

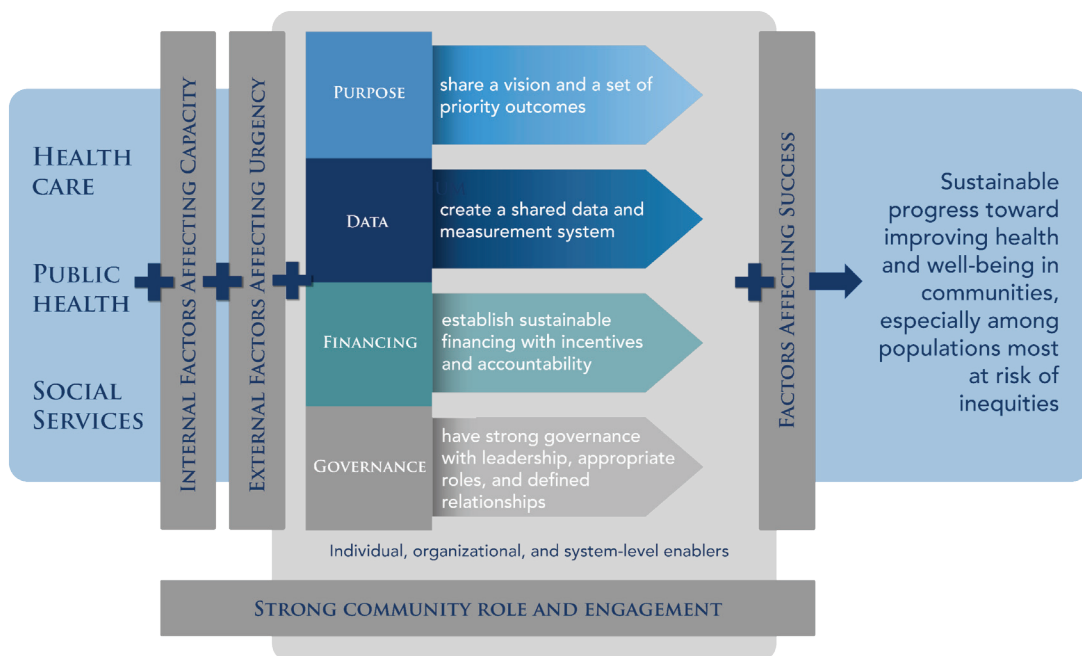
- Increased recognition of the social determinants of health (SDoH),
- The passage and implementation of the Affordable Care Act (ACA), and
- The spread of initiatives focused on value-based systems change.

Such developments highlight the ways in which factors outside clinical care can shape population health. This, in turn, focused attention on cross-sector collaboration.

As a major supporter of research and practice aimed at improving population health, the Robert Wood Johnson Foundation (RWJF) has, along with its partners, closely observed the shift toward cross-sector collaboration. Among its key observations are that while collaboration has achieved success in some cases,¹ it has yet to generate the hoped-for major improvements in population health and health equity. It is time to rethink cross-sector collaboration.

Drawing on its experiences with research and practice in collaboration, RWJF is developing the theory of change to move the field forward (see Figure 1). At its root is the hypothesis that lasting and effective solutions to population health problems are more likely to emerge when organizations from the health care, public health, and social services sectors move beyond small-scale collaborations to create lasting alignment in at least four dimensions: *shared purpose, governance, finance, and data*. We refer to this cross-sector, cross-dimensional process as *alignment*. The four dimensions are the theory of change’s four core components, yet the theory also includes other essential elements such as capacity, urgency, and community voice. The desired outcomes of alignment are community well-being and population health equity.

Figure 1. The Cross-Sector Alignment Theory of Change



In this chapter, we discuss our examination of existing literature on health-oriented cross-sector collaboration. Our research sought to explore two questions:

- What factors shape, promote, or inhibit cross-sector alignment?
- What are the outcomes of cross-sector alignment?

Fully answering these sweeping questions will ultimately require considerable time and effort on the part of many people. To manage the scope of this project, we focus on health-oriented collaboration literature that addresses the four core components of cross-sector alignment: shared purpose, governance, finance, and data. Further, to keep both communities and equity at the forefront, we also examine health-oriented collaboration studies that address community voice and equity.

METHODS

This literature review is a scoping review — that is, it focuses on a broad topic rather than summarizing findings regarding a specific causal relationship (as in most Cochrane Reviews). Our topic is the discussion of cross-sector alignment’s core components in the literature on health-oriented cross-sector collaboration. We gathered the documents for the review using three approaches: a purposive scan, a systematic scan of key journals, and a systematic scan of academic search engines.

Purposive Scan

We employed several purposive document-collection strategies that leverage professional networks at RWJF and the Georgia Health Policy Center (GHPC). These strategies included the following:

- Reviewing documents of interest forwarded by RWJF, such as those used in the preliminary development of the theory of change.
- Systematically scanning the RWJF website for relevant work on alignment, including searching for projects in the Grants Explorer database that contain the word *align*.
- Scanning for reports on the websites of key contacts and organizations identified throughout the project.
- Collecting key documents identified through RWJF and GHPC contacts that we encountered before and during the project, including the Technical Advisory Committee.
- Conducting ad hoc web searches on key terms.

Our purposive scan yielded 148 reports and academic journal articles for analysis.

Systematic Scan of Key Journals

Using the documents collected and a preliminary search on several academic search engines as a guide, we identified four journals as being particularly relevant to the project: *The International Journal of Integrated Care*, *Social Work in Public Health*, *Health and Social Care in the Community*, and the *Journal of Public Health Management and Practice*. Two researchers scanned articles published in these journals since 2010 for two criteria, including them if they addressed:

- Health-oriented collaboratives, and
- At least two of three key sectors of interest (health care, public health, and social services).

We excluded articles if they recommended collaboration but did not discuss it in the core of the paper. We also excluded articles if an English-language version was unavailable. We resolved disagreements about inclusion and exclusion in conference; where such disagreements were not resolvable, we included the documents.

Systematic Scan of Academic Search Engines

We searched Academic Search Complete, PubMed, and the Cochrane Library using a search term that reflects the objective of identifying studies addressing health-oriented cross-sector collaboration:

(multi-sector OR multisector OR “multi sector” OR cross-sector OR “cross sector” OR intersectoral OR inter-sectoral OR multisite OR multi-site)

AND (collab OR partner* OR integrat* OR joint OR alliance OR allied OR coalition)*

AND health

AND (((healthcare OR “health care”) AND (social OR communit))*

OR ((healthcare OR “health care”) AND “public health”)

OR ((social OR communit) AND “public health”))*

For each search engine, the first 800 articles were assessed for inclusion using the same

criteria as with the systematic scan of journals; in total, we included 571 reports and academic journal articles in our analysis.

Coding

We collected information for each document in a data-extraction matrix that includes the following: author, year, title, type of document, analytical class (theory building or theory testing), key findings as stated by the author(s), whether it addressed each alignment component, key findings related to the core components, the evidence basis, which outcome measures were used, and who funded the project. Our analysis focused on the information relevant to the four core components, community voice, and equity; we thematically coded subthemes within each area of interest. The resulting themes and subthemes are presented below.

RESULTS

Shared Purpose

Of the 571 documents included in the literature review, 264 articles contain information that directly relates to *shared purpose* — our umbrella term for the ways in which purpose is discussed, including as goals, vision, mission, and outcomes. Many of the documents simply identify shared purpose as an important component of collaboratives.²⁻¹⁸ They also include shared purpose as a recommendation,¹⁹⁻³¹ and two documents refer to it as an overarching framework for collaboration.²⁰⁻²¹ Further, while many articles do not include shared purpose as a key component of their analyses — instead, simply recommending that collaborations develop it — the sheer number of articles that refer to it speaks to the importance that analysts assign to shared purpose.^{19, 22-23, 31}

We now highlight papers in which shared purpose is a key analysis component. That is, they address the development of shared purpose and discuss how it contributes to the success of collaborations, how it relates to barriers, how it relates to other theory of change components, and what it focuses on.

Promoting the Development of Shared Purpose

The literature identifies several factors that may promote the development of shared purpose. Trust is cited several times as an important factor,³²⁻³⁷ as is the inclusion of community members in agenda setting.³⁸⁻⁴⁰ Community health needs assessments (CHNAs) and community health improvement plans also present opportunities to develop shared purpose.⁴¹⁻⁴² Collaboratives can use the data that emerges to identify needs and, ultimately, a shared purpose.⁴³⁻⁴⁵

Having a structured planning process to identify a common mission and common goals is also recommended as a way to develop shared purpose.⁴⁶ While researchers identify several specific approaches, Dalton et al. suggest that taking a flexible approach — which places more importance on aligning objectives and principles — may be helpful.⁴⁷ For example, organizations might give their stakeholders opportunities to openly engage; Kritz found that this could help promote openness and creativity, which in turn could promote the organic development of shared vision among organizations that might not typically collaborate.⁴⁸

While many papers suggest developing a strong sense of shared purpose, some note that it remains important to attend to the differences between organizations; doing so allows collaboratives to remain responsive to participating organizations' diverse goals.⁴⁹⁻⁵⁰

Shared Purpose as a Facilitator of Collaboration

Many of the studies suggest that shared purpose contributes to the success of collaboratives.^{46-47,51-66} This success, however, is defined in various ways. One paper defines success as improvements in an initiative's specific outcomes,⁵⁵ while other papers define it as improvement in the collaboration as an organization.^{58,60} Notably, several studies suggest that the partners involved in collaborations that have an established shared purpose are more likely to perceive their collaboration as successful.^{46,59} Other studies suggest that instituting accountability for measures connected to shared purpose can help organizations focus — and ultimately promote alignment.^{12,67-68}

Shared Purpose and Collaboration Barriers

Although many documents suggest that shared purpose contributes to collaboration success, others suggest that the process of developing shared purpose can sometimes slow down

collaborative efforts.⁶⁹⁻⁷⁹ Holt et al. observe that even when different sectors are brought together, they may not automatically feel committed to pursuing health as a shared objective.⁷⁶ Such cases often involve organizations with conflicting mandates or interests.^{70,77-78,80-82} Reconciling differences in values between organizations in the private and public sectors is noted as a particularly acute challenge.⁸³⁻⁸⁵

Problems also exist in the development of shared outcomes relating to SDoH or specific subpopulations, such as older adults.^{69,74,86-87} Among the challenges here are defining and measuring outcomes, understanding and defining the risks related to SDoH, and a lack of cross-sector knowledge of issues affecting different population groups.

Negative perceptions of collaborative partners may also affect the ability of collaboratives to develop shared outcomes successfully.⁸⁸ In one example, organizations outside the public health sector were resistant to collaborating with health departments because they viewed their own goals as different from public health goals, even though a review of each organization's goals showed many similarities.⁷³

Finally, as we noted earlier, while most studies suggest that developing shared purpose is important, some emphasize the importance of highlighting differences in organizational needs and perspectives.⁸⁹⁻⁹⁰

The Timing of Shared Purpose in Collaborative Processes

There is a debate in the literature as to when collaborating organizations should focus on shared purpose. Several papers suggest that organizations should have or develop similar shared values before partnering — with some going so far as to call it a prerequisite.⁹¹⁻⁹⁶ If shared purpose is identified by organizations before collaborating, they can use that purpose as a catalyst for working together.⁹⁷⁻⁹⁸ If shared purpose is not addressed early on, preventable barriers may emerge in the collaborative process.⁹⁹⁻¹⁰⁰ Developing shared purpose early can provide an opportunity for partners with differing goals to find compatibility or consensus from the start.¹⁰¹⁻¹⁰³ Identifying shared purpose early also draws out potential gaps in data and helps identify partners that may benefit from strong data-sharing processes.⁹⁷

Although the literature often suggests either beginning with a sense of shared purpose

or developing that shared purpose early on, one article suggests that building shared purpose in collaborations after relationships are established can help smooth its development.¹⁰⁴

The Focus of Shared Purpose

Establishing shared purpose can help to both define measures of success and assess a collaborative's outcomes. Notably, however, many of the studies that address shared outcomes do not discuss specific outcomes defined in the process of developing shared purpose. For studies that do mention specific outcomes, four include individual-level outcomes, usually tied to a specific strategy or intervention,¹⁰⁵⁻¹⁰⁸ and five include population-level outcomes, such as improving neighborhood health.¹⁰⁹⁻¹¹⁴

Clavier et al. caution against developing shared outcomes that focus too narrowly on the individual, especially when local community SDoH are not considered.⁷⁹ Such outcome measures may divert the collaborative from focusing on populationwide health improvement and inequities within those populations. Kyriacou also suggests that collaborations adopt population-level shared outcomes, noting that individual-level outcomes — such as increased referrals — can be problematic if they are not linked to net benefits for the whole community.⁵⁰

Other studies suggest that shared purpose should focus on equity,¹¹⁵ and several identify equity-focused outcomes, such as improving the well-being of refugees.¹¹⁶

Shared Purpose and Accountability

Instituting accountability for measures connected to shared purpose may help organizations focus, and thus ultimately promote alignment.^{12,67-68} Collaboratives developing shared outcomes might also consider including short-term goals or “wins” to offer external accountability to funders.¹¹⁷

Discussion: Shared Purpose

Key Consideration — Impact

The research we reviewed presents many perspectives on how shared purpose should be developed and how it impacts collaborations. Up to the time of this review, we found little research

that provides a clear picture of the link between collaborations developing shared outcomes and changes in downstream population health outcomes. Although many collaborations include shared outcomes in their work, subsequent analysis is lacking. In most of the studies we reviewed, evidence comes from case examples or key informant interviews. Few of the comparative analyses actually tested aspects of shared purpose. This should be an area for future research; those in practice could help the field by designing programs and evaluations that support such analyses.

Those studies that do assess collaboration outcomes generally found positive results; the collaborations led to improvement in either a specified health outcome or in the collaboration itself. However, the role that shared purpose plays in those relationships is less clear. Future research can explore this link.

Key Consideration — Definitions

Within the literature, shared purpose is not a consistently defined concept. Future research could productively explore how best to define it in such a way that collaboratives aiming for cross-sector alignment could learn from each other and from the research literature. We may need different definitions for different types of shared purpose. It is also likely, however, that focusing efforts on developing measures that are useful across various situations will help to identify which practices are most effective in which contexts.

Tensions

The literature on shared purpose includes several divergent findings. When considering how the theory of change components are implemented on the ground, divergent findings may ultimately affect the ability of sectors to collaborate effectively. Some of the differences identified here include different perspectives on the importance of developing shared outcomes for successful collaboration, on when shared outcomes should be developed, on structured versus flexible development processes, and on the importance of addressing individual-level versus population-level outcomes. Future research could address some of these inconsistencies through systematic analyses, especially if the analyses account for complexities such as differences in contexts.

Links to Other Theory of Change Components

We found notable overlap in the literature on shared purpose and other theory of change components. How a collaborative addresses governance, finance, or data ultimately affects how it addresses shared purpose (and vice versa). This points to possibilities for looking at the theory of change components as fluid processes rather than as static or isolated elements. Given this perspective, we might visualize the theory of change as largely cyclical in nature.

The overlap between shared purpose and governance is notable. Several studies suggest that convener organizations may be able to play the role of helping the collaborative define its shared purpose.^{67, 118-120} Leadership in general was identified as important for developing shared purpose. Leaders can help develop a vision for the collaborative, and changes in leadership or ineffective leadership may weaken the collective vision.¹²¹⁻¹²² One study, for example, notes a case in which teams lacked leadership and felt that they accordingly lacked the vision to maintain their collaborative efforts.^{7*}

In relation to finance, a sense of shared purpose can help the collaborative overcome skepticism and protect funding sources.¹²³ Kaufman et al. found that organizations may be resistant during the collaboration's initial stages because they fear that other sectors will take over scarce funding.¹²³ The collaborations that address these issues do so by developing shared priorities, jointly applying for funding from new sources, and building trust.¹²³ Consensus on shared purpose may also help promote confidence that there will be a return on investment (ROI).¹²⁴ Financial accountability can be tied to collaborative results; in such cases, it is important not to disproportionately orient program activities only to short-term outcomes.¹²⁵ One recommendation is to tie financial accountability to longer-term ROI outcomes even though they are more difficult to measure.¹²⁵ This may be accomplished through policy initiatives that require financial accountability for health outcomes.¹²⁶

Data can play an important role in setting goals and measuring health.¹²⁷ Exploring shared data may at times act as a driver for developing shared purpose,¹²⁸ while limiting shared data can impact the ability of collaboratives to measure outcomes that reflect their shared purpose.⁶⁵

*As noted below, there are conflicting perspectives on the meaning of strong leadership.

Governance

Of the 571 documents included in our literature review, 280 contain information directly related to governance. With few exceptions, researchers studying health-oriented cross-sector collaboration suggest that governance can strengthen collaboratives.^{62,129-134†} While many consider human factors — such as leadership and roles — important, others emphasize governance structures.³⁵ We first address the literature on governance structures. This is followed by a section on roles, then a section on leadership specifically. The final section includes a discussion with overall reflections on governance and issues that researchers and practitioners may want to consider further.

Governance Structures

Governance structures take many forms,^{12,136} ranging from informal agreements among a few parties to large, formal organizations involving powerful businesses and governments. Such structures also have varying origins. They might be rooted in state requirements or community needs.⁶⁷ They might be driven by political, economic, cultural, social, or organizational contexts.¹³ They might emerge organically, where each partnering organization has a similar mission — though even in these cases, researchers recommend creating new, unifying structures.⁹⁶

Time

Governance structures may change within collaboratives over time.⁴⁶ In some cases, their configurations may reflect earlier, ineffective governance structures.¹³⁷ Southby and Gamsu argue that collaboratives generally need time to establish effective and sustainable governance.¹³³ Chutuape et al. found that, over time, the collaboratives they studied became more structure-focused, involved less-diverse sectors, and became more targeted — including toward systems with a broader reach.¹³⁸ As we describe in more detail below, institutionalization is a likely development over time. Given such changes, researchers at the Health Foundation note that developing good change-management structures can greatly benefit cross-sector collaboratives.³⁷

† One exception is Ovseiko et al.,¹³⁵ who suggests that, within a collaborative, the idea of governance may be more important than governance itself. Another exception is Holt, Carey, and Rod, who suggest that even where structures are reorganized across sectoral boundaries, new boundaries will inevitably be created.⁷⁶

Institutionalization

Especially in more complex cases, collaboratives may move toward institutionalization.⁸³ In relation to such movement, the literature suggests professionalization of leadership,¹³⁹ having a website and meeting often,¹⁴⁰ training,^{22,141} gradual partnership building,³⁰ and even establishing systems that are difficult to undo.⁵⁶

Many studies discuss formal and informal agreements. Sabina, for example, emphasizes the importance of contracts,³⁰ and Erwin et al. found that organizations are more engaged when their partnerships included formal written agreements.¹⁴² Among other functions, contracts help define expectations and align financial incentives,¹⁴³ help align services,¹⁴⁴ and help define accountability systems.²² Entrance to collaboratives may itself be formalized,¹⁴⁵ for example by signing membership commitment forms.³³

While there may be benefits to contracts, the literature also gives reasons to be cautious about contractual arrangements. For example, because contracts tend to be bilateral, they do not always lend themselves to collaborative work among many partners.¹⁴³ Ovseiko et al. found that avoiding complex legal arrangements can speed up an initiative.¹³⁵ Some researchers suggest finding a balance for formal and informal arrangements.^{13,145} In one such example, Freda highlights memoranda of understanding as potentially useful tools.⁹³

Scope and Processes

However it happens, many studies highlight the importance of establishing scope agreement (see also “Discussion: Shared Purpose” above).^{16, 88, 121} In one example, the Public Health Leadership Forum suggests defining the interventions. In another example, van Duijn et al.⁷⁰ point out the importance of defining logistical processes, while others suggest standardizing procedures more generally.¹⁴⁶⁻¹⁴⁷

Notably, Amarasingham et al. state that effective processes can at times be difficult to define.¹⁴⁸ Structured governance can be difficult to achieve, can require resources, and might sometimes best be approached not as a set of imperatives but as a set of decisions to be made.

Transparency

In the studies we reviewed, calls for transparent governance structures are common.^{22, 47,}

^{121,149-153} In one example, Kennedy et al. call for transparent agendas,¹⁵⁴ while in another, Esparza, Velasquez, and Zaharoff argue for transparent budgets.¹⁴⁹ Transparency about participant roles is also a common theme.^{70,141,155-159}

Consistent with these studies, the lack of clarity was in several cases identified as a barrier. Esparza, Velasquez, and Zaharoff note that collaborators without a model on which to base their work can end up with a disconnected array of ad hoc efforts.¹⁴⁹ Gottlieb et al. observe that bureaucratic barriers can conceal processes in managed care organizations, and note that in such cases it is nearly impossible to determine best practices if the status quo is maintained.¹⁶⁰

Administration

Grudinschi et al. suggest having dedicated administrative functions.¹²⁹ Several studies include calls for continuous improvement, monitoring, and learning.^{13,70,145,161} In some organizations, these sorts of processes may already exist in some form, and several studies recommended building on structures that are already available.^{50,162}

Context Conscious

Several studies also recommend being context-conscious when developing governance structures. A study by Rasanatan et al. recommends efforts to understand the political ecosystem,¹⁶³ while one study by Vermeer et al. suggests targeting outcomes that could have a visible impact on the surrounding community, thereby increasing community support.¹⁶²

Person-Centeredness

When defining interventions, Guyer, Garcimonde, and Striar recommend that cross-sector collaboratives engage in a paradigm shift, moving away from devoting attention to eligibility determination and toward placing consumers at the center when developing a program agenda.¹⁶⁴ This reverses the conventional logic of bringing people to a service and requires close attention to creating services that reflect people. Van Duijn et al. also suggest that collaboratives can and should move toward person-centeredness, which they defined as “the development of integrated services and information flow which is tailored to a particular individual or target group.”⁷⁰ Pires and Stroul recommend an individualized approach to collaboration that involves wraparound services. Such

an approach displaces the convention of requiring individuals to seek many services, instead bringing many services to individuals.^{161‡} In the “Role of Community Voice” section below, we discuss ways to involve consumers and communities in program design so that programs better reflect individuals and communities.

Equal Partnerships

Several studies suggest creating governance structures with equal partnerships at the core. A study by Bromley et al. includes calls for institutionalized equity at the partnership level, meaning “innovations that would increase transparency and normalize information exchange, share agenda-setting and decision-making power with partners, and institutionalize partnering through training and accountability.”²² Rasanathan et al. also suggest moving away from dictatorial leadership and toward distributed leadership, especially after a collaboration is initiated.¹⁶³ However, equal partnerships can be difficult to achieve. Hendricks et al. point out that some managers may feel disinclined to collaborate because they may feel they are losing status when confronted with distributed leadership structures.⁷³

Group Work

Teamwork came up many times in the review. The Health Research & Educational Trust highlights the importance of working from consensus across partners.¹⁴⁵ Similarly, Paris et al.²⁵ advocate pushing through the inevitable challenges and remaining loyal to the team approach. A paper by Calencie et al.¹⁶⁵ also includes calls for group problem-solving, while Tsuchiya et al.¹⁶⁶ suggest workgroup subunits and task forces.

Buy-In

Several studies highlight the importance of gaining buy-in across the collaborative, both for leadership¹⁶⁷⁻¹⁶⁸ and other collaborators.^{121,167} Buy-in can be defined in different ways. Here, it is understood to mean support for a collective objective. Sometimes, this can mean financial support,

‡ See the following section, as well as the debate on individual vs. population-based interventions in the earlier “Shared Purpose” section.

though buy-in is typically discussed in terms of a good-faith commitment to action. Hedbert et al. stress the need for organizations to gain buy-in with both internal and external stakeholders.¹⁵⁶ Ayala et al. note that it may be productive to establish quasi-formal buy-in with a written document, even if the document is not formal in the legal sense.^{169§}

Roles

Roles were a frequent topic of discussion in the health-oriented cross-sector collaboration literature on governance.^{101,170} Six types of role were commonly discussed: collaborators, conveners, central committees, funders, data managers, and staff or front-line workers. Communities and governments also play important roles.

The Role of Collaborator

The literature highlights several needs that partnering organizations have when developing governance structures. These include the need for leadership within individual organizations,^{39,171} a need for relationship building up front,¹⁷¹ a need for trust,^{88,92,133,172} a need for balance between sectors,⁷² a need for training,^{146,173} a need for space for experimentation,^{70,173} and a need for partnership values.¹⁷⁴

Several studies identify important considerations for collaborators in specific sectors. For example, Holt, Carey, and Rod found that in collaboratives, public health organizations are sometimes marginalized relative to health care organizations, and this can be true even when public health representatives are placed in the central organizing unit.⁷⁶ Hawke et al. also note that collaborations between social service and health care professionals are particularly challenging, perhaps due to systematically differing priorities.⁵⁴

Within the health care sector, Turner found that collaboratives involving health care do not necessarily have to be large, well funded, or top-down, but that they are more likely to be effective when health care leaders simply recognize that change is needed in order to benefit the people they serve.⁹⁹

§ Ayala and colleagues added that this might also be a good time to collect survey data.

The Role of the Central Committee

Several studies found that central committees play an important role in collaboratives.^{46, 175} Among other things, central committees can connect partners, set strategy, and guide the progress of working groups.^{83, 176} The central committee may also be able to enforce accountability among working groups.¹⁷⁷ However, a study by Holt et al. cautions that intersectoral committees may risk settling into patterns in which they are used only for sharing information.⁷⁶ Those considering a central committee structure may want to account for these possibilities in their planning.

Convener

Much of the literature focuses on the role of conveners, and several studies explicitly indicate that conveners are very important to collaboratives^{11, 67} and inevitably shape the collaborative's approach.¹⁷⁸ A study by the Center for Sharing Public Health Services and the Public Health National Center for Innovations suggests that conveners help provide momentum, facilitate interactions, create a shared vision, and build measurement practices.¹⁰¹ Mongeon, Levi, and Heinrich emphasize functions such as strategy development, vision guidance, and public will-building.¹¹⁸ Spencer and Freda suggest that conveners help guide shared purpose, engage the target community, facilitate convenings, manage the budget, oversee data and measurement processes, and ensure transparency.⁶⁷ Hoe et al. note that conveners may facilitate information exchange, resource sharing, and trust-building.¹⁷⁹ Other potentially important convener functions include revitalizing relationships¹⁴⁵ and establishing governance rules.¹⁸⁰ In terms of timing, Hoe et al. suggest that conveners are especially important at the beginning of collaborative efforts, and Nemours notes that complex systems may need multiple conveners.¹¹

Several studies note that particular conveners seem common among particular organization types. For example, relatively large organizations and financing streams often have health care organizations as the convener,¹¹³ while SDoH-oriented collaboratives are more likely to have social services organizations as the convener. Public health organizations often make good conveners, as they often have expertise in convening and engaging diverse stakeholders.^{101, 119, 181}

The literature also includes various traits that conveners may need to ensure success, such as advanced-planning experience,¹¹⁷ the ability to gain trust from participating organizations,^{117, 180} and the ability to be transparent.^{11, 117} The AcademyHealth and National Health Research Institutes

also suggest that inclusiveness is critical for conveners.¹¹⁷

The Role of Funders

Funding and the incentives that come with it are often viewed as critical for collaboratives.¹⁰¹ Although we discuss this role in detail in the “Finance” section, funders can also contribute to collaboratives in nonfinancial ways, such as by aligning their efforts across their grantees.¹⁸²

The Role of Implementers and Data Managers

Several studies discuss implementers, noting that collaboratives should be attentive to workload and overwork,⁷⁵ and that implementers may need guidance and support⁷⁰ and may benefit from training.¹⁵⁷

Data managers play a key role in governance structures, as data governance can be a considerable challenge.¹⁸³ Perhaps because of the combination of potential rewards and substantial challenges, several studies highlight the importance of data managers.^{18,101,184}

Several studies also discuss implementer collocation — that is, workers from different backgrounds working in the same physical space, which boosts the potential for close communication. An example here is a social worker assisting with social service needs screenings in a doctor’s office. Hunt advocates collocation,¹⁸⁵ though others indicate that it might be ineffective in some cases, especially if workers remain physically distant despite being in the same building, or if there is a lack of governance structures to direct and incentivize collaboration.^{153,186}

At the individual level, Holland et al. found that the role of care coordinator can be pivotal for making the most of the consumer’s time and of the capacity of collaboratives and their constituent organizations.⁸ Studies also found that some individual health care professionals may have work routines and professional identities that hamper collaboration, and they thus may need extra help.^{147,153}

The Role of Community Voice in Governance

Community voice plays an important role from design through implementation and evaluation.¹⁸⁷ Placing community voice at the center of collaboratives can increase their real and perceived value in the community’s eyes.¹⁶² Several studies found community voice especially

important for driving priorities.^{38,64,188} Sometimes, however, bringing community voice into governance structures can be challenging,⁸¹ and collaboratives that anticipate such challenges may be better situated to achieve their goals. **

The Role of Government

Several studies discuss the role of the government or, more specifically, the role of states. Government involvement in health-oriented collaboratives is generally discussed as a benefit,¹⁸⁹ especially in cases where the government has significant experience.¹⁹⁰ Governments can provide resources,¹⁹¹⁻¹⁹³ help with coordination,¹⁹⁴ and provide collaboration support to their governmental subunits.¹⁹² Perhaps most of all, governments can create a legal environment conducive to cross-sector alignment.^{48,132,184,191,195} For example, governments can align certifications¹⁷⁶ or even mandate participation in collaboratives.^{137,196-197} Conversely, government support can be a barrier in some cases, such as those in which the government has inadequate resources or lacks commitment.¹⁹⁸

The studies we reviewed pay particularly close attention to states, which in some ways are well situated to assist, coordinate, and bring in partners from multiple sectors¹⁹⁹ (as in the case of interactions with Medicaid²⁰⁰). As a result, some view states as particularly important to collaboration across sectors,⁴⁹ with one paper suggesting that a state-level champion is useful to have from the very beginning.³⁰

Leadership

In our review, we found leadership to be the most-discussed governance element; indeed, many researchers consider leadership and leadership structures essential for success.^{62,75,201-202}

Origins of Leadership

Leadership can emerge from various sources, including from any of the involved sectors or from champions of specific causes.⁴⁶ Sources of trusted information may also be elevated to leadership,²⁰³ as may government representatives.⁹⁵ Critics can be a source of leadership when the collaborative addresses their concerns.⁹⁵ Notably, Humowiecki et al. recommend drawing

**See also the “Community Voice” section below.

leadership from those with lived experience in the targeted community.¹⁸⁷

Leadership Roles

Just as the origins of leadership vary, so too do its roles. Among the most important roles may be helping to create a sense of shared purpose or helping to keep the big picture in focus^{121, 204-205} (see also the “Shared Purpose” section). Other leadership roles include creating a climate of problem-solving,²⁰⁵ finding resources and bringing in strategic partners,¹⁶⁶ and leading change management.^{193,206}

Leadership Challenges

Several studies note that finding effective leadership can be difficult.^{139,207} Key challenges include inattentiveness, diversions, and short attention spans. The latter is especially challenging in cases where ROI is expected only over the long term.^{121,208} Studies also note that it can be challenging to balance representation of the various sectors¹³⁹ and to include government departments, agencies, and ministries at all levels.²⁰⁹

Leadership Changes

Changes in leadership and leadership roles are likely over time,¹⁶⁶ and this can create challenges. Because leaders often champion the collective vision, leadership changes can affect the sense of shared purpose felt by collaborative members.¹²¹ Changes in government leadership, for example, can make it difficult to maintain a sense of collective purpose.²¹⁰ Asserting authority late in the process is also a potentially critical problem for collaboration.¹⁴⁹

Leadership Attributes

Suggested attributes for leaders vary across studies, but the need to establish buy-in among leaders is a common theme.^{46,64,145} Several papers call for collaborative and inclusive leadership, an understanding of inclusive care, and the ability to build consensus and foster cooperation.^{13,47,70,73,178,204,206} Another recommended attribute is diversity, specifically in terms of intergenerational power dynamics,³⁸ though other dimensions of diversity — including race, ethnicity, gender, and sexuality — are important as well. Smith et al. also suggest having representatives from each sector on the leadership team.²¹¹

Leadership Recommendations from the Literature

The literature lists many recommendations for promoting effective leadership. Perhaps foremost is the recommendation to clarify roles, accountability, and incentives^{171,206} and to do so at all levels.^{47,178,212} Training is also recommended.^{60,73,187,213} In some cases, establishing legitimacy is important,²¹⁴ though Erickson et al. note that in their study, less than half of the observed leaders obtained legitimacy from the grassroots.²⁰³ Developing a change-management plan for leadership is also important¹⁴⁵ — though studies often emphasize the importance of continuous leadership.^{72,214-215} Finally, as we noted earlier, several authors suggest distributed leadership structures, in which partners share leadership power.^{22,163}

Discussion: Governance

Key Considerations — Resources

Several studies argue that resources are a key requirement.^{133,137,216} Resources are important for many reasons, not least of which is that they might eventually be tied to incentives.^{150,163}

The Health Research & Educational Trust suggests that some of these resources might be available in the community.²¹⁷ However, time, money, and other resources are sometimes scarce. In any case, implementing various elements will likely require trade-offs; even if we had a blueprint for governance that every collaborative could follow, collaboratives would still have to make strategic decisions about which elements to prioritize. As our research once again reinforces, governance is as much a series of decision opportunities as it is a set of imperatives.

Key Considerations — Impact

Structured governance can have many benefits. Perhaps most fundamentally, it is a form of communication and information sharing.¹⁵² Structured governance can also help build trust.¹³ Hoedemakers et al. went so far as to suggest that collaboratives with structured governance might have enhanced negotiating power.²¹⁸ Measurable outcomes themselves are cited as an important governance objective (see also the “Data” section below).¹⁸⁸

Nevertheless, as we note in the “Shared Purpose” section, our review shows that not all collaboratives measure their governance outcomes. There may be many reasons for this, including

that measuring outcomes can be quite difficult.²¹⁹ In any case, the lack of outcome data presents considerable downstream challenges for practice and research. Because the literature contains few systematic comparisons of collaboratives with and without specific governance systems, it is difficult to draw firm conclusions about preferred practices. So, ultimately, our governance findings are composed of observations from the literature that have yet to be rigorously tested, and care should be taken when deciding how to implement different governance systems.

Tensions

While the above considerations should serve as food for thought for anyone engaging with health-oriented cross-sector collaboratives, the considerations are perhaps more decision opportunities than well-established imperatives. This is true for several reasons. First, as we note above, few of the literature's governance propositions have been formally tested. Second, only a few collaboratives analyzed in the literature have achieved an advanced state of development.¹³² Third, contexts vary widely among collaboratives,^{132,220} and the link between these contexts and governance considerations is not well understood. Fourth, and perhaps most relevant for our purposes, several key tensions have emerged in the literature on collaborative governance.^{††} This section addresses some of those tensions, all of which highlight the fact that governance structures vary by context — and may indeed need to do so.

Among the more straightforward tensions that the literature explicitly identifies are those between maintenance versus production activities;¹³ the need for government involvement versus the difficulty of working with governments, such as due to leadership changes, policy change, and capacity limitations;⁸⁵ and the need for replicable structures versus contextualized solutions.⁷⁹

Other tensions emerge when we step back from the literature and view it as a whole. For example, there is tension in how we might understand history: existing relationships are sometimes identified as very helpful^{46,49} and other times described as a barrier, especially when existing relationships are poor.⁶⁸

Similarly, there is tension in how we might understand flexibility versus commitment. Some

^{††} Tensions have already been identified above in relation to contracts versus informal agreements and equity versus status.

studies emphasize the benefits of flexibility,¹⁹ especially in terms of leadership.¹⁵¹ Yet one study argues that when a collaborative introduced flexibility, it did little to increase the understanding of different professions, data sharing, the collaboration's goals, or the potential marginalization of representatives from different backgrounds.²²¹

In contrast, other papers emphasize commitment,⁷⁰ while still others recommend both flexibility *and* commitment.^{83,214} Certainly, these differences in emphasis reflect the fact that flexibility and commitment can — and probably should — be applied strategically in different ways at different times. The point is that both practitioners and researchers should understand that decisions around flexibility and commitment are complex.

Likewise, the literature reflects a need to carefully consider sectoral diversity. Although the literature often discusses inclusiveness, it is not clear how far it should extend into the representation of different types of organizations. It is perhaps easiest to assume “the more, the merrier.” Yet while some studies point to several benefits of inclusiveness — including diversity of human and financial resources¹³ — others identify challenges that may result when a wide range of organizations are at the table.^{88,222} For example, potential partners may have distinct processes and distinct needs,²²³ different policy goals or territories,⁷³ and divergent mandates.^{80,90,224} These differences might turn into significant challenges and can create delays or stoppages. This is not to suggest that sectoral diversity is bad, but rather to note that it should be thoughtfully managed.

Several of the tensions identified here fundamentally concern the balance between streamlining processes and maintaining high participation levels.¹⁷⁷ This is also true of the most salient tension the literature identifies: that between strong leadership and open dialogue. Although not always defined, strong leadership is explicitly highlighted as important in many studies,^{46,121,133} at all levels,⁹⁵ and sometimes even in direct relation to open dialogue.²²⁵ Studies discuss strong leadership as being intentional, visionary, and charismatic.⁴⁶ It is viewed as a means of addressing sustainability;²⁰⁹ the need for inspiration;⁹⁵ the need for vision, resources, and support;⁷ and the need for investment, especially when ROI is expected only in the long term.²²⁶

In contrast, many other studies emphasize facilitative or less hierarchical leadership.^{29,62,91,227-228} Again, as with “strong” leadership, facilitative leadership was recommended at all levels²⁰⁵ and for many reasons, including its potential for building trust, leveraging partners’

unique strengths, helping develop common aims and measures, and reducing redundancy.^{122,228} Facilitative leadership can also reduce issues with sustainability in that it can help to avoid both personification of the collaborative²¹⁵ and dependency on specific leaders.⁷

Much of the difference of emphasis on varying leadership styles can be reduced to nuance. For example, the Health Foundation calls for leadership that is strong but not top-down.³⁷ Such examples highlight the fact that leadership style, like other variables that emerge, can be complex and may need to be carefully considered.

The final tension we discuss here does not emerge explicitly in the literature, but rather becomes apparent when we observing the literature as a whole. This is the tension between structure and leadership. While many of the papers discuss structure, it is clear that considerable emphasis also falls on leaders. This is important for those interested in moving from collaboration to more robust and long-lasting alignment. The focus on leaders may backfire when changes occur, as they inevitably will. Governance structures that effectively anticipate change, including leadership changes, may prove more sustainable than those that rely primarily on active leadership.

Links Between Governance and Other Theory of Change Components

In many ways, governance links together the other core components of the theory of change. Governance is especially linked to shared purpose, since shared purpose provides goals around which governance structures can be created. Governance is also important for finance, since it is generally necessary to define responsibilities related to financial management and sustainability. Finally, governance is critical for managing data processes (as we describe in more detail below).

Finance

Here, we present key findings from the literature addressing financing in cross-sector collaboration. Of the 571 documents included in our literature review, 233 discuss financing as a relevant component of alignment. Findings from the documents varied widely. Prevalent themes include types of financing mechanisms (such as those that finance collaborations,

finance collaborative initiatives, and catalyze collaboration), financing and barriers, financing and facilitators, financing and sustainability, and financing in relation to other theory of change components. These themes and the findings that constitute them are discussed below. At the end of this section, the literature is discussed as it relates to finance as a whole.

Types of Financing Mechanisms

Many studies suggest that financing is needed for an effective and sustainable collaboration.^{2,5-6,36,105,109,129,141,145,163,168,188,191,194,217,229-242} At a more specific level, several documents highlight the need for funding dedicated to collaborative processes themselves, as opposed to programs or interventions.^{3,74,112,150,243} Despite extended discussion on financing mechanisms, research to date suggests that partnerships often lack structured financing processes.¹³² While many mechanisms have been tried, financing remains an important challenge for many collaboratives.

The financing mechanisms that the studies discuss most often include grants, blending and braiding, and outcome-based payments. These are addressed in more detail below. Other financing mechanisms include private donations,²⁴⁴ personal health budgets,⁶⁶ and shared savings and global payments.²⁴⁵

Grants

Many studies describe grants as the most common funding mechanism.^{7,9,192,246-252} Grants are considered especially important to the startup of collaborative work,²⁴⁷ and the role of grants may change over time.²⁴⁶ For example, the Accountable Communities for Health (ACH) collaborative models were initially funded by federal grants, but they are beginning to transition to other funding sources such as foundation grants, state funds, funds from reimbursement of care coordination services, and reinvestment of funds from partnering agencies.²⁴⁶

Blending and Braiding

The ACA made it easier for organizations to blend and braid federal funds,¹⁰⁸ and organizations are increasingly incorporating these funding mechanisms into their collaborations.^{39,94,108,253-254} Blended funding is used to combine funds from different sources into

one pot from which funds can be drawn. In contrast, braided funding keeps funds separate but coordinates their use for specified projects or initiatives in accordance with the respective funding sources' requirements.²⁵³ One study describes a case in which braided funding was a key factor in a successful partnership,⁹⁴ while another recommends blending funding because it is more flexible.²⁵⁵

Both braided and blended funding mechanisms have their challenges.¹⁰⁸ Organizations may resist braiding because it entails barriers to spending. Or, they may resist blending because they fear losing control over how funds are spent.¹⁰⁸ Further, Clary and Riley found that blending or braiding funds under a single state agency may be hindered by differences in agency cultures and reporting requirements.¹⁰⁸

Performance-Based Payments

The ACA promoted the shift from fee-for-service payment mechanisms toward performance-based payments. As such, it was an important waypoint for collaborative work between health and non-health-oriented sectors.²⁵⁶ Financing models associated with performance-based payments include wellness funds, risk-sharing arrangements, Medicaid waiver demonstrations, social impact bonds, hospital community benefit programs, value-based purchasing, and Medicaid capitated managed care models.^{118,257-259} Early results from an evaluation of social impact bonds show that they have promise as a strategy for nontraditional funding for housing-first initiatives.²⁶⁰

Collaboratives using the ACH models report successful use of wellness funds as a financing strategy for collaboration.^{31,261} Wellness funds “pool resources from a variety of sources: government grants; philanthropic contributions; individual donations; donations from participating stakeholders; captured savings resulting from agreed-upon interventions; and other joint ventures that bridge health care services and efforts to address the social determinants of health.”²⁶¹ Alignment strategies that facilitate the use of wellness funds include developing a shared purpose, using governance processes to build trust within the collaboration, hiring individuals with experience managing complex funding streams, and building accountability measures into the collaborative.²⁶² Accountability can be built through monitoring progress, ongoing evaluation, and documenting ROI for short- and long-term wins.²⁶² To sustain these funds, recommended priorities include strong stewardship of the collaborative, the voices of the community and of nonhealth stakeholders, and creative thinking on how to align funding streams.²⁶²

Financing Mechanisms and Catalysts for Collaboration

Many of the identified financing mechanisms act as catalysts for collaboration, especially when they are promoted or enhanced by the ACA.^{44,136,178,256,263-266} Examples include aiding the blending and braiding of Medicare and Medicaid funds,¹⁰⁸ incorporating community benefit dollars into the tax-exempt status of hospitals,⁴⁴ and increasing funding for substance use disorders, which led to an increase in collaboration between behavioral health and medical providers.²⁶⁵

Although value-based purchasing arrangements were identified as catalysts for collaboration,^{187,257,259} the effects of these systems on collaboration are inconsistent and unclear. One Australian study found performance-based funding to be a barrier to integrated direct care service.²⁶⁷

Within the U.S. health care system, Gottlieb et al. found that using health care funds to address prevention can be difficult where there are prohibitive policies, as is the case with Medicaid in some areas.¹⁶⁰ Notably, however, a policy analysis by Goldberg, Lantz, and Iovan suggests that Medicaid funding is more flexible than many people suspect.²⁵⁷ As the U.S. health care system moves increasingly toward value-based care strategies, these findings might be useful to collaboratives contemplating this type of funding for their work.

Funders and organizations might also consider how finances can incentivize collaborative work.^{21,159,268} For example, one study found that there are financial benefits for local government participation in a collaborative, though it found no observable financial incentives for community-based organizations (CBOs) to participate.²⁶⁹ Accountable Care Organizations (ACOs) use per-member, per-month payment systems to aid in care management for their high-risk populations, and this provides financial incentives for social service organizations to collaborate with the ACOs.^{245,270} However, another study found that payment incentives may not be enough to motivate hospitals to invest in programs that refer high-risk patients to social service organizations.²⁷¹ The lack of available flexible payment models also creates a barrier for health care organizations in engaging and incentivizing social service providers.¹⁴⁸

Financing and Barriers

Government Funding

Government funding is typically viewed as a catalyst for collaboration, but it is not

without challenges.^{206,223,272-273} A Massachusetts study shows that after implementation of the ACA, Federally Qualified Health Centers saw an increase in patient volume even though increased health coverage was supposed to increase preventive care and ultimately reduce patient volume.²⁷³ Wright and Nice argue that this may create competition between Federally Qualified Health Centers and local health departments.²⁷³ Further, federal funding budgets are often overseen by different congressional committees. This can create informational barriers that contribute to the lack of evaluation of the impact of collaborative programs, obscuring program effects and endangering support and sustainability.²²³ Such issues can affect a collaborative's ability to obtain and sustain federal funding. Finally, government funds often include usage regulations that may make them harder to use for collaboration.²⁰⁶

Lack of Funding

When a collaborative cannot obtain financing, various issues may arise.^{60,157} One study found that funding mechanisms favored health systems; this may cause funding insecurity for other sectors and thereby inhibit collaborative efforts.²⁷⁴ Nonhealth sectors face added burdens, with budget cuts that make addressing health issues difficult.⁷³ Several studies cite the lack of financial resources available to social service sectors as a problem.^{84,87,275} Such problems can limit the ability of social service organizations to collaborate with health and public health organizations. Organizations from rural communities are also affected by limited financial resources, and they often have a difficult time accessing federal grant funding.¹²²

Despite these barriers, individuals in one collaborative that lacked funding said they were still providing services.¹⁵⁵ This suggests that while funding is important for many reasons, it may not always be necessary. It also suggests that social contracts can be important in collaborations as a supplement to financial contracts. Indeed, studies found that, in some cases, budget cuts and the lack of financing actually focused collaborative efforts.^{46,154}

Financing and Facilitators

One study found that public health funding can be more easily obtained when there is collaboration with the community.²⁷⁶ Indeed, many sites participating in the ReThink Health

Ventures project said they were able to raise significant funds as a consequence of their collaborative activities since those activities helped them gain clarity on the value of the collaboration, their regional structure, and their purpose.²⁰⁸ One study, however, found that direct payments from individuals, rather than through collaboratives, may be a more appropriate funding strategy for populations with complex needs.²⁷⁷ In this study, individuals with severe mental illness perceived increases in their autonomy when using the direct payment method for their services.²⁷⁷

Financing and Sustainability

Financing is critical for collaborative sustainability.^{12,41,49,53,117,190,278-280} One paper offers a concrete example of sustainable financing in the form of a bundled-payment contract system for funding elderly care.²¹⁸ In this case, care groups negotiate with health care insurers for a fixed annual budget to cover all elderly care. The study notes that having insurers involved in the process is difficult, but that it can help sustain the collaboration.²¹⁸

Many collaborations struggle to find and/or implement sustainable financing.^{62,101,120,203,270,281-283} Indeed, the ReThink Health evaluation shows that obtaining long-term financing is the biggest challenge.^{203,208} Few sites use diverse or innovative funding mechanisms (such as dues or membership fees) and half of the partnerships did not see a need for using different financing structures.²⁰³ Many of these collaboratives are funded through time-limited grants. Although some studies suggest that grants can be a sustainable funding mechanism, others identify grants as unsustainable.^{77,281,284}

AcademyHealth notes that few collaborative projects have demonstrated positive ROI, which is hard to achieve but can help demonstrate to funders a collaborative project's viability and efficacy. Further, short grant-funding periods can inhibit collaborations from sustaining their work, as they often plan it around the funding instead of the other way around.²⁸⁵⁻²⁸⁶ One study suggests that multiyear funding is needed for collaborations to be successful.²⁸⁷

An evaluation of ACH models identifies four key principles for collaboratives to achieve financial sustainability. First, such sustainability depends on strong leadership, which is defined by an individual or organization's ability to influence and motivate internal and external actors.³¹ This influence is critical in making ACHs a priority within health system transformation.³¹ Second,

ACHs should have financial transparency, which is part of building trust within the collaboration.³¹ Third, developing and measuring shared goals legitimizes collaborations and helps track outcomes for potential future funding.³¹ Finally, investments are needed from a variety of stakeholders that benefit from the collaborative (especially health payers).³¹

Discussion: Finance

Key Considerations — Comparing Financing Mechanisms

The literature identifies several mechanisms that collaborations have used to manage financing over the past decade. Although these mechanisms vary widely, few studies have compared them or assessed the contexts in which they are most effective. Further, in the assessments that do exist, the results vary across studies. Collaboratives must negotiate a range of incentives and disincentives when engaging in collaborative finance; identifying and negotiating these factors is an important part of developing sustainable financing.

Key Considerations — Funding Sources and Financing

Although the studies extensively discuss funding mechanisms, a focus on funding sources is less common. Medicare and Medicaid are frequently cited as collaboration funders, and changes in their rules can be important for collaboratives. However, few studies discuss taking an active role in influencing government funding policy.²⁸⁸ Similarly, there is little discussion of trying to actively shape the private insurance industry. This suggests an open space for research on how collaboratives are — or might take — an active role in relation to funding sources. These considerations will be especially important as organizations continue to shift from smaller collaboratives toward aligning structures.

Tensions

Several findings in the financing literature diverge, including those related to funding strategy, financial incentives, and lack of financing. Several studies indicate that grants are the most common form of funding for collaborations.^{7,9,192,246-252} However, in some cases, grants are seen as an unsustainable funding source,^{77,281,284} yet few studies explore the transition away from

grant funding to more sustainable funding mechanisms. Collaboratives using the ACH model have progressed the most in this area and have reported success in using wellness funds as a financing mechanism for their initiatives.^{31,261}

Performance-based payment models have potential to shape collaborative work.²⁵⁶ While such models are in various phases of implementation, however, the outcomes remain inconsistent or unclear.^{160, 267} Further, while formal contracts outlining financial incentives can facilitate collaborations,¹⁴³ results from one study suggest that financial incentives may not always work or may not be strong enough in the health care sector.²⁷¹

Finally, although lack of financing is a significant barrier for many collaborations, budget cuts sometimes help focus collaborations¹⁵⁴ or act as a catalyst for collaboration.³¹ Exploring such tensions in the future will help guide both research and practice.

Links Between Financing and Other Theory of Change Components

Several studies discuss financing in relation to other components of the theory of change. Regarding shared purpose, collaboratives may prioritize funders' goals when defining goals and objectives. Regarding governance, funding can be used to promote leadership, engagement, and accountability within the collaboration.⁴⁸ Governance structures that align grant objectives and timelines from various federal funding streams can help facilitate collaboration.¹⁵⁶ Regarding data and measurement, data can demonstrate impact and efficiency in order to obtain or maintain funding. In some cases, requiring data-sharing practices may disadvantage smaller organizations that cannot afford technologies such as electronic health records systems.⁵⁴ Even larger organizations can be affected as well, as they can also face issues with financing the data improvements and infrastructure that collaborative processes might need.²⁸⁹

Data

Of the 571 documents in the literature review, 216 contain information that directly relates to data and measurement. Here, we review papers in the health-oriented cross-sector collaboration literature relating to data and measurement. Several themes emerged during our review, including needs, helpful conditions, challenges, implementing shared data, and opportunities and use cases.

These themes and the findings they represent are discussed below; we then conclude this segment with a discussion of the literature on data and measurement as a whole.

The Role of Data

According to many papers we reviewed, data and measurement are critical for effective health-oriented cross-sector collaboration.^{3,37,62,93,95,145,150,167,178,188,226,236,263,290-293} Data sharing may even be the fundamental impetus of many collaboratives.²⁹⁴ There are many reasons to engage with data and measurement, and many ways to do it. However, effective data sharing is often challenging, and these challenges range from the minute to the monumental. As noted in earlier reviews of cross-sector collaboration, many collaboratives struggle with operations as basic and foundational as demonstrating impact.²⁹⁵ In many collaboratives, data sharing and management remain largely aspirational²¹² or rudimentary.⁹⁴

There could be multiple causes for this. For example, the collaboratives simply may not be effective. Given the shortage of conclusive research at this stage, we should consider this possibility thoughtfully. Another possibility, however, is that the measurement process itself is not as effective as it could be. While none of the studies actually test either of these alternative theories, most adopt the latter.

The studies we reviewed suggest that many factors are needed for an effective collaborative data and measurement system. For example, it is important to identify shared needs and gaps,^{97,161,193} as well as the needed datasets.²⁹⁶ Further, collaborators must determine whether and how the data will be obtained.¹⁶ Finally, the studies recommend systematic investments in information technology¹³⁷ and the establishment of data-governance processes.²⁹⁷

Data Sources

Data may come from various sources. Health care providers often have useful data.²¹² While the United States lags behind some other countries in defining and enforcing data interoperability standards, provider data has become more accessible following the economic recovery laws of 2009, which included the passage of “meaningful use” laws that promote standards for electronic health records.²⁹⁸ Community-level data is available from local health departments²⁹⁹ or through

community health assessments, which are more common since the 2010 passage of the ACA.²¹² Some data may be available in very simple form such as on public websites or in shared spreadsheets.³⁰⁰ Preliminary data might also be obtained through interviews or surveys conducted with partners, contacts, and group members.²⁰⁹

Agreements

Organizations wishing to share data will likely need to enter into formal agreements.^{16,161,226,301} Consent may also need to be obtained from the consumer. This could happen through a signed consent form, though working with such forms may be difficult when consumers are experiencing crisis.²⁹⁶ A potentially effective strategy mentioned in multiple papers was to obtain consent for later services during an initial service encounter.^{118,249}

Helpful Conditions

Context will likely play a significant role in collaborative data sharing, and the National Center for Complex Health and Social Needs recommends that collaboratives be mindful of their environment.⁹⁷ Capacity within and across organizations will likely be a factor,¹²⁴ including available technical tools or infrastructure,²⁸⁹ as well as technical assistance. Assistance for practitioners transitioning to electronic health records and for CBOs with limited infrastructure is especially helpful,^{54,199} as is assistance in preparing and consolidating data at the organizational level.²¹¹

Other aids include financial resources,⁵⁴ a formal governance structure to provide direction,⁵ and a backbone organization to provide coordination.²⁷¹ The legal environment also plays a role in shaping opportunities. For example, the government might mandate the collection and provision of useful data.³⁰² The government might also provide standards to help with systems interoperability^{227,303**} and standards for working with deidentified data, both of which are identified as important facilitators.^{34,192} Availability of individual data is particularly helpful in some cases,^{30,167} as is data on pilots that show early success.²⁴⁹

**The collaborative itself may also establish standards.

Challenges

The literature also references many challenges; as we discuss below, system interoperability, gaining permissions, and capacity are the issues mentioned most often. Other challenges include time lags,^{34,67,207} lack of resources,^{128,209,304} lack of cross-sector communication,³⁰⁵ ethical constraints,^{78,306-308} and inadequate rigor in systems development and data analysis.³⁰⁹

Equitable Data Management

A set of challenges that is often discussed at professional conferences — but surprisingly, has yet to make substantial inroads in the literature — is the challenge of equitably managing data privacy, security, and ownership. For people tasked with aligning personal data across organizations and sectors, the technical barriers and rules involved raise considerable challenges. How to manage this data ethically is an issue on which the literature offers little guidance.

Interoperability

Lack of interoperability is cited numerous times as a key challenge for data sharing. Often, organizations have information systems in place, but they are incompatible or difficult to integrate.^{78,114,206,285,310} Standards that span systems are often nonexistent, undefined, or obsolete.¹²⁸ Standardized health outcome data is especially difficult to coordinate, and shared patient information is also noted as particularly hard to attain and share.⁸⁶ A key problem is the lack of collaborative infrastructure, such as laws that incentivize data exchange or documented processes for developing and implementing standards.^{67,311}

Humowiecki suggests that the lack of health outcome data may be contributing to overreliance on cost and utilization measures.¹⁸⁷ That is, interoperability problems may be shaping the agenda of health system reform quite broadly.

Other factors may also contribute to interoperability problems. Issues with integrating proprietary systems can slow or even halt data-sharing initiatives.¹⁸⁷ And even when it is possible to link systems technically, legally, and ethically, data-sharing efforts can still be hampered by a lack of consistency in how the available measures²⁰⁶ and systems are used.³¹¹

Permissions

A second major barrier that multiple studies note is the difficulty in obtaining data access permissions. Many of these challenges are rooted in security and legal limitations.^{67,78,94,118,305,312} One case even cites legal issues as the most challenging of all barriers to cross-sector data collaboration.³¹¹ Even when legal issues are overcome, data may still be restricted. Other issues include managing security protocols⁹⁴ and implementer concerns about liability, coercion, misuse of data, or other ethical issues.¹²⁸ In other cases, competitors within a collaborative may withhold data,⁴³ and despite communication and high-level commitment, data agreements may never arrive.²⁰²

Data and Capacity

A third challenge the literature frequently cites is limited capacity. The required data systems are often complex.¹⁰³ Some organizations do not understand how to set up data requirements or data dictionaries to help with interoperability.³⁰ Organizations may not have or follow established processes for data collection.⁷⁵ A technical platform or technical know-how are also often lacking, especially among CBOs with relatively limited resources.¹⁴⁸ Organizations sometimes implement systems despite capacity shortages. This is risky, as bugs in pilot systems may cause participants to disengage.¹⁷⁷

Implementing Shared Data

While the literature points out many challenges, it also includes many recommendations for sharing data. An underlying theme across papers is that organizations may be able to overcome many challenges with thoughtful solutions and intentionality.

Identifying need is a first step in many cases. At this stage, many papers suggest engaging with members of the target community and with the implementers.^{212,312} The initial stages may also be a good time to evaluate the environment and retain legal counsel to research and address data-sharing questions.^{97,296}

Once need is established, goals can be identified. The National Center for Complex Health and Social Needs suggests taking the time to negotiate goals with partners.²⁹⁶ Many authors identified the need to make the case for interventions, perhaps using preliminary data if it is available.^{5,94,97,190,232,253,312}

An evaluation plan is also recommended,^{16,297} and measures will need to be identified. Recommendations for measures include tying them to goals^{103,127} and including health outcome measures.⁹⁴ The status quo — often using indirect measures — is considered less than ideal,⁹⁴ but moving beyond it may be challenging. However, van Dijk explicitly recommends pursuing difficult outcome data because it is often what is most needed in specific cases and — in the case of actionable research — for the field in general.²⁰⁵ Other recommendations include choosing metrics that reflect realistic quality and accountability goals,²⁵³ not developing and using too many indicators around too many things,¹⁰³ and including process measures along with the outcome measures.¹⁶

Initiating Data Sharing

Initiation approaches vary significantly. Some papers recommend starting small and targeting simple, short-term wins, while others suggest planning well into the future and beginning with significant investments. These pathways are not mutually exclusive, but most organizations tend toward one or the other path, and the choice will likely have significant implications for the initiative.

Papers that recommend going for initial short-term wins note that doing so can help bring in investors.¹¹⁷ This strategy might also be accomplished with fewer resources by leveraging existing data and adapting existing technologies.^{97,117,137,209,313} Those emphasizing long-term planning and large early investments anticipate more ambitious systems that will more effectively support integration efforts, measure impact, and encourage investors in the future.^{67,130,177,253,306}

Institutionalizing Shared Data

Several papers recommend various forms of institutionalization. Examples include establishing IT support up front,²⁵³ standardizing systems and data input tools,^{117,137} ensuring that data flows in both/all directions,²¹² and building infrastructure such as a synchronized medical

records system.^{112,117} Data use agreements are also needed.¹¹⁸

Tips for Shared Data Implementation

Several papers offer tips for initializing data-sharing arrangements. For example, organizations can reduce concerns over the legal liabilities associated with data privacy by providing written tools that help implementers and participants understand which activities are appropriate.^{296,312} Organizations can also create online dashboards to help orient partners¹¹ and workflow or case management software to make IT administration easier.⁶⁹ Organizations that lack technical expertise might find it elsewhere, such as through a collaborative partner⁶⁹ or a specialized contractor.^{285,312}

Opportunities and Use Cases

Once implemented, shared data can be used for many purposes. Most fundamentally, it can help organizations design and evaluate cross-sector interventions.^{94,314} This is ideal, if not necessary, for initiatives involving performance-based incentives.^{106,178,232,238} Many studies also highlight using information-practice feedback loops as a good general practice.^{13,16,21,49,67,78,89,101,124,188,267, 285,291,304,315}

Seeing with Data

Many of networked data's benefits center on what it lets people "see." For example, it can help organizations identify opportunities for collaborative action to improve health.^{2,45,67,74,94,109,212,316-317} It can also help them identify potential partners for a collaborative.¹⁷⁴ Linking data to geographical information systems to find "hot spots" in need of interventions was also cited as being particularly useful.^{34,53} In one case, cost-effective hot-spotting helped a collaborative reduce violence-related injuries.¹⁵² Shared data can also help identify unmet needs at the individual level,^{54,315,318-319} perhaps even detecting the early onset of disease.³²⁰ Finally, shared data can help organizations identify service eligibility for individuals.³¹²

Different Types of Data

Organizations can collect many different types of data.²¹² An organization might already collect some types of data, while other types might need to be created or collected. Context data,

for example, is now recognized as very important.³²¹ Such data might include resources available to community members, local health hazards, and maps indicating high-need areas. Consumers might share medical histories (with permission),¹²⁸ while individuals or communities may collect resilience factors³²¹ or screen for or gather SDoH data.^{21,34,118,249,291,312}

Organizations might also collect health outcome data^{187-188,226,270,302,322} as well as proxies and alternative outcomes measures such as service utilization,^{67,187,238,322} readmissions,³⁰¹ and preventable care.^{55,321} Organizations can also collect program administration data, which is intrinsically valuable; examples here include cost data^{31,55,187,191,322} and referral data.^{270,281} One particularly interesting innovation is to obtain consent for follow-on services when the need is identified at the initial point of service; this allows follow-on services to reach out directly to consumers. In one case, this approach increased uptake of nutritional services by 75% compared to a conventional referral system.²⁴⁹

Technology Innovations

While even basic data innovations may help with alignment, the possibilities for leveraging technology are many. One paper recommended making shared data available in real time,¹²⁵ while others suggested leveraging emerging technology or familiar consumer technology, including using cloud technology,³²³ offering online portals,²⁴⁵ providing clients with tablets,²⁷⁰ using text messages,²⁴⁹ and implementing push notifications.²⁸⁵

Enabled Processes

Shared data enables processes that might not otherwise be possible. Collaboratives might offer joint programs.^{211,294} Collaboratives or individual organizations might also use the data for advocacy,^{56,209,294,324} or they might tie policy decisions directly to data assembled by aligned organizations.^{191,209} The data might also be used to address fundamental theory in research, providing a firmer basis for practice across the entire field.^{67,163,178,314,325-326}

Benefits to the Aligned Operation

Ultimately, a number of benefits are expected to accrue to aligned organizations with shared data. Examples include the opening of pathways to more thoughtful service delivery,³¹⁴ increasing

trust,¹⁵¹ identifying people and communities frequently using services,³⁰⁰ and reducing redundancy by ensuring that member organizations are not collecting the same data.^{151,285} Research to date suggests that those with integrated data systems see boosted service use, reduced wait times, and better clinical outcomes.^{54,327}

Discussion: Data

Key Considerations — Resources and Data

As in other areas, cooperative data and management can be complex and resource-intensive. This section included strategies for overcoming resource barriers, as well as reasons to reach hard toward distant aspirations. This again highlights the idea that decisions will have to be made, and the optimal decision may differ depending on the context.

Key Considerations — Ethics and Data

Ethics are a subtle undercurrent throughout much of the literature on collaborative data. Ethics in this context are important for two reasons in particular. First, while many studies identify privacy barriers as a key challenge, these barriers are, in many cases, designed to protect consumers and communities. Although they surely benefit other interests in some cases, it is important that collaboratives emphasize a community-based orientation and bear in mind that communities bear much of the risk of poorly handled data. This relates to the second reason ethics are important here: ethical challenges speak to the issue of having community voice as part of the governance team, especially in relation to data governance. In this way, creative solutions may emerge that respect the privacy of individuals and communities and promote data protections that serve as a barrier only to the extent that they are protecting the community.

Tensions

Many papers agree on major challenges and opportunities, but several tensions nonetheless emerged between different studies. Perhaps most fundamentally, many papers suggest that data sharing is “hard,”¹¹⁴ yet not all subscribed to this perspective. Tsai and Petrescu-Prohava suggest that data sharing takes relatively little resource investment, and Johansson and Liljegren note that there is a great deal of data available. Perhaps some of the mismatch is only in perspective. This

may be a case in which context matters. Taking the above studies for example, it may be that data systems in China (Tsai and Petrescu-Prohava) and Sweden (Johansson and Liljegren) are already systematically more integrated than they are in the United States (Sandberg).

Another topic where suggestions differ is outcome measurement. Consistent with the notion of cross-sector alignment, there were calls for better measures that reflect the ultimate outcome, especially health outcomes,¹⁰³ and, consistent with the findings of this review, a lack of effective outcome measures was identified in several earlier reports.^{94,127,187,205,309} There is much to suggest that a more aggressive pursuit of — and reporting of — health outcomes would be helpful where possible, difficult as obtaining that data might be, especially in the short term. Perhaps surprisingly, however, a second set of studies emphasizes process measures,¹⁶ in some cases calling for even more attention to them.^{122, 187} While seemingly counterintuitive, this second suggestion might be best placed in the context of practical realities. Where actual health outcomes are impractical to measure, it might be useful to note alternative successes if they can indeed be considered successes in themselves. Whether they can and should in themselves be considered successes should perhaps be asked when the program and the evaluation study are first being designed.

The third and perhaps most thought-provoking tension is between different modes of initializing shared data. As noted above, some studies suggest an approach that uses available resources and demonstrates quick successes to help get the alignment off the ground.^{97,117,137,209, 313} Others emphasize long-term planning and significant early investment.^{130,177,253,306} The point is not that these diverging emphases are mutually exclusive. Rather, the point is that organizations are deploying different strategies, and future researchers and practitioners may benefit from being thoughtful about their own approach, especially given variations in contexts across aligning collaboratives.

Links to Other Theory of Change Components

Data serves as the basis of many things that go into and come out of cross-sector alignment. This is especially true when it comes to shared purpose.^{226,253} Many of the studies recommend measuring progress toward the shared purpose as a good practice. In some cases, organizations are even required to demonstrate progress toward collective goals, which makes data fundamental to

the finance component of cross-sector alignment.

Governance and data are also linked. While many either ignore data and measurement or take it for granted, the studies reviewed here suggest that ambitious data plans are more likely to be effectively implemented if they are guided by effective governance, including data governance. However, such management can be both technically demanding and resource intensive.

Community Voice

Of the 571 documents included in the literature review, 132 contain information directly related to community voice. This factor is particularly prominent in the theory of change because it is generally understood that community voice should be important in relation to all of cross-sector alignment’s individual components. It is especially relevant for grounding efforts to achieve the specified outcome of the theory of change: sustainable progress toward improving health and well-being in communities, especially among populations most at risk of inequities.

Here, we focus on studies that address community voice. The themes include community voice as a tool for health improvement, community engagement via CBOs, community voice as a driver of cross-sector collaboration, and strategies for community engagement. These themes are discussed below, followed by a discussion of the literature on community voice as a whole.

Community Voice as a Tool for Health Improvement

Community voice discussions most often appear in the context of assessing community needs and community participation in priority-setting for health improvement; examples include CHNAs and health impact assessments (HIAs).^{§§} These assessment processes can be an important way to engage communities around health care and health improvement. Community participation in CHNAs and HIAs can improve understanding of SDoH as well as the local health and social service system.^{43,328}

Service implementation studies describe community voice as the engagement of end

^{§§} For more on priority setting, see also the “Shared Purpose” section above and the conclusion’s “Key Observations.”

users to test program design, to inform program design and increase the odds that programs are tailored to the clients' needs,^{116,329-330} to evaluate provided services to ensure that they are patient-centered,^{47,218} or to promote awareness of health or other programming in a specific community or population.³³¹⁻³³²

The literature offers only limited discussion on the depth and quality of community engagement, and few articles offer details about specific strategies for effective community engagement. We found scarce evidence of community engagement's impact on health improvement, yet research suggests that community engagement — especially during program design — can result in more effective and sustainable health programs.

Indeed, community engagement is often limited to defining or assessing health needs or to evaluating their experiences with existing services; consumers are not typically engaged in generating solutions or driving innovation in service provision.²²² The literature did note, however, that citizen participation in health assessment and health service planning processes can provide opportunities for community engagement in activism and advocacy around issues related to health equity and access.^{118,328}

Community Engagement via Community-Based Organizations

In this literature, CBO engagement is often discussed as a proxy for community voice and end users. CBOs are largely assumed to be well connected and to possess a deep understanding of both the target populations and their needs.^{109,231}

A few authors argue that the U.S. health care sector is largely unprepared to appropriately and adequately partner with community-based entities; to get there, studies suggest that we must make efforts to build health practitioner capacity through trainings that promote increased focus on community culture and community-scaled health needs.²³¹

Community Voice as a Driver for Cross-Sector Collaboration

Consumer engagement is often presented as ideal — even a best practice. The literature, however, contains little information about strategies for engaging consumers and communities in cross-sector collaboration.^{19,333} A few articles propose tools or frameworks that could be used to promote full, focused community engagement. For example, collaborations might use driver

diagrams to organize community engagement, focus discussions, and draw out health-related community priorities in a more comprehensive way.⁴⁰

Bromley et al. focus on *procedural justice* as a way to increase the odds that communities are fully engaged in the collaborative. They define procedural justice as “procedural innovations within health systems that would support equitable partnerships including innovations that would increase transparency and normalize information exchange, share agenda-setting and decision-making power with partners, and institutionalize partnering through training and accountability.”²²

External actors or policy can also drive community engagement. Buffardi, Cabello, and Garcia describe the role that donors play in mandating civil society engagement — and particularly the engagement of marginalized populations — in cross-sector collaboration.¹³⁹ However, they caution that external imposition of cross-sector collaboration, and the mandated inclusion of marginalized groups, may imply inclusion when it does not effectively exist.^{139,196} Conversely, without political will or funder support for an effort, community engagement is less likely.¹⁹⁸

Bureaucratic procedures, coupled with a lack of policy supports, can disadvantage certain groups and disincentivize community engagement. Without structures to support communities engaging on equal footing, a lack of trust in the process and in the partners’ results can arise.²² Governance structures that include partners from under-represented communities offer an opportunity for those communities to build both capacity and social capital. The result can be a more accessible community health delivery system that is better held accountable to the community.³³⁴

Community perspective is typically described as important for informing cross-sector collaborations that attempt to better meet the needs of the populations served.³³⁵ As one study notes, “Learning to see the health care system from others’ perspectives allows for a clearer understanding of the problems facing the population being served, how a range of organizations in the health and social sectors aim to address those problems, and how the changing dynamics might help or impede partnership success.”³³⁶

Strategies for Community Engagement

Codesign

Codesign engages service users as experts who collaborate with service providers to incorporate the users’ ideas into intervention design.^{306 330} User perspectives shed light on patient

experiences with accessing care, and they promote a better understanding of the care-delivery context.^{47,330}

Community-Based Participatory Research

Several studies mentioned community-based participatory research in terms of its implications for specific populations (for example, people with mental illness), ways that it can improve clinical delivery and improve care coordination,³³⁷ and how it might produce more sustainable health initiatives and health outcomes.⁵⁶

Participatory Budgeting

Participatory budgeting couples community engagement with budgetary empowerment. It can increase commitment and trust, produce different ways of public spending, and promote both government transparency and public participation. Hunt argues that participatory budgeting in health and population health work is rare and should be expanded. However, both de Leeuw and Hunt caution that community participation — including participatory budgeting — should not be seen as a fix-all since it can be resource-intensive to develop community capacity for engaging with evidence and concepts such as SDoH.^{56,185}

Community Organizing

Building community capacity is a key objective of community organizing. Community organizing aims to develop a community's ability to engage in advocacy and policy change work.³⁰⁶ Community organizing is often used by nongovernmental CBOs.¹²¹ However, since it improves a community's capacity for engagement, and since community engagement is widely considered important for collaboration, community organizing can be used in collaboration much more broadly and may be a key tool for cross-sector alignment.

Discussion: Community Voice

Key Considerations — Drawing on the Community Engagement Literature

We can draw several overarching observations about community voice from the literature. First, there is a need to strengthen connections between the cross-sector collaboration literature and

the literature on community engagement. The collaboration literature notably lacks a description of strategies for meaningful community engagement, as well as findings that connect that engagement to stronger program design, better uptake, or improved outcomes.

Key Considerations — Models for Centering Community

The literature offers examples of how certain actors can work to promote community engagement, such as through backbone organizations in ACHs or public health workers in CHNAs. However, the field would benefit from added clarity on how differing values around, and practices for, engaging community might impact efforts to build cross-sector alignment. The current lack of specificity on methods for engaging community voice and experience suggests that it may be helpful to identify or develop new models and strategies for engaging community voice in alignment efforts. For example, by testing a theoretical or practical framework for community engagement in collaboratives, the differences across sectors in timing, quality, and strategy of community engagement could be better understood.

Key Considerations — Mapping Community Voice

It is broadly acknowledged that consumers may experience fragmented services when sectors are disconnected from the voice and experience of the populations they are nominally intended to serve.¹²⁹ Indeed, studies now present community engagement as critical for achieving improvements in population health and health equity.^{21,129,188} Several studies also place a high value on community centeredness, in which community members, patients, and consumers are actively engaged in priority-setting.^{49,70,147} When community voice is a part of health needs assessment and direction-setting, it will likely lead service providers to better recognize collaboration's benefits, smooth the consumer experience, and better meet community needs by jointly addressing SDoH. In terms of the cross-sector alignment, this suggests that community voice could shift to the left side of the theory of change as a driver of collaboration, or perhaps become a fourth sector or even a fifth core component.

Tensions

The importance of community voice for informing and/or driving efforts to improve

population health is nearly universally acknowledged. However, the definition of community voice varies, as do proposals for how to engage it. As we note above, engaging CBOs as proxies for community voice is one way that health and other sectors bring the experiences, needs, and perspectives of community members and service end users into discussions about health improvement efforts.^{109,231} Other strategies for bringing community voice to the table focus more on the direct participation of community members or service end users.^{19,333} The implications of such alternatives are not well understood, but choices between the two likely affect the depth and quality of community engagement both within and across sectors.

Links to Other Theory of Change Components

The literature discusses community voice as a driver of collaboration in two particularly important ways: by driving priorities and shared purpose, and as a component of governance. As we note above, developing shared purpose can involve, or be driven by, the inclusion of community members in agenda setting.³⁸⁻⁴⁰

An analysis of themes across papers on community voice also suggests that when community voice is central and local actors from across sectors understand service users' challenges in navigating complex systems, cross-sector alignment may be more effective. Building mechanisms that include community voice is a part of governance, and several articles discuss how governance structures can support the engagement of community perspectives and voice, such as by assigning the backbone or coordinating agency the role of seeking out community perspectives, or by requiring advisory boards or other bodies to retain community members.^{118,328}

Equity

Of the 571 documents in the literature review, 85 explicitly discussed equity. Indeed, alignment outcomes can be measured in terms of population health equity, and equity is generally promoted as a key consideration across all alignment components.

The literature focuses on equity across several axes of marginalization, including race and ethnicity,^{4,338-340} sexual orientation and gender identity equity,³⁸ indigenous communities,³⁴¹⁻³⁴² age,³⁴³ immigration status,^{53,344} and socioeconomic status.^{53,234} Across these marginalization axes,

equity is discussed primarily in terms of procedural equity and health disparities.

Themes include barriers to addressing equity; workforce development and equity; community voice, community services, and equity; links between equity and the core components of alignment; and equity as an outcome. We then conclude this section with a discussion of the literature on equity overall.

Barriers to Addressing Equity

Several articles address barriers to successfully addressing equity. One found that insufficiently coordinating policies, ignoring SDoH, and collaboration stakeholders not understanding the link between health and social development all affect the development of a comprehensive approach to health equity.^{194,345} A lack of political commitment and poor resource allocation also impeded Spain's implementation of the National Roma Integration Strategy, which in turn affected access to health care, limited participation in decision-making processes, and ultimately created barriers to addressing inequities.¹⁹⁸

Workforce Development and Equity

In addition to immediate barriers, historical context and structural impediments to addressing equity also exist.⁴⁹ At the individual level, public health workers may need to develop the ability to understand and address health equity and the structural and practice-based inequities that endure from colonialism, patriarchy, and class-based prejudice.³⁴⁶ Learning about and acknowledging histories of governmental structural oppression can also improve relationships with community leaders.³³⁸

Changing the hierarchical structure of the health care workforce to include social workers, health care workers, and consumers may also help improve health equity.³⁴⁷ Such changes are expected to have important outcomes since policy workers in social sectors more frequently support policies and activities related to reducing health inequity as compared to other sectors.³⁴⁸ Consider that one study found that individuals working in health care placed a relatively low priority on interventions that address health inequities.²⁸⁰ Policy recommendations might productively include equity training for providers.³⁴⁹

Community Voice, Community Services, and Equity

Studies cite community voice as a mechanism through which alignment may improve health equity,³⁵⁰⁻³⁵¹ especially when using strategies to engage community members that are attentive to power dynamics.³⁸ One way to include equity in alignment is therefore to build relationships with community leaders,¹¹⁸ and two papers suggest that community health workers are well positioned to address SDoH.^{198,352} Another means of leveraging communities to improve health equity is to provide community supports for maternal and child health concerns.³³

Equity and Policy Reform

Reforms within the health care system specifically are needed to help address equity, particularly in terms of access to health care and payment systems.³⁵³ Efforts can be built into collaborations to promote these reforms.³⁵⁴

Leaders from health systems and CBOs also identified a need to improve procedures in public agencies and recommend increasing transparency, normalizing information exchange, and sharing agenda setting and decision-making, which can support partnerships with communities.²² Reform on the national level may also come from establishing Health in All Policies, with health equity as the goal.²⁵⁹

Links to Other Theory of Change Components

Governance, Data, and Equity

It may be important to address inequities within partnerships themselves. For example, training regarding equity within partnerships may be warranted.²⁷² Equity can also be built into mission statements,²¹² and mission statements, goals, and outcomes that are community-driven can promote equitable partnerships.^{21,188} According to Gettinger et al., equitable partnerships can lead to new perspectives being heard and subsequently result in positive outcomes.³⁵⁵ In one example, stakeholders working with immigrant and indigenous communities found that building collaborations based on the knowledge of those communities was critical.^{341,344} One study discusses how HIA can allow community voices to promote programs and services for underserved populations,³²⁸ while another suggests that collaborative leadership can play an important role in

promoting equity.³⁵⁶ A population health data and measurement system may also promote better tracking of health equity outcomes, which may in turn help improve those outcomes.³⁰²

More generally, the literature suggests a focus on ethics and processes to support equitable partnerships.²⁷⁹ To that end, frameworks are available to help assess partnerships' attempts to achieve equity.¹⁴²

Finance and Equity

Funding mechanisms also can be used to address equity within collaborations. Accountable Health Communities (AHCs) are an example. AHCs were funded under the State Innovation Model grant through the Centers for Medicare and Medicaid Services. AHCs are explicitly required to address health disparities.^{3,67} One AHC, for example, focuses on equity in SDoH, and specifically on poverty and education.²⁹⁷ Collaborations can help to find diverse funding streams to address equity.³⁵⁶

Financing can also be a barrier to addressing equity; public funding is lacking for vulnerable adults, for example, which in turn creates a barrier for sectors to collaborate to address this issue.³⁴³

Equity as an Outcome

Several articles report on collaborations that include health equity as an outcome.^{4,58,120,234,337,340} Of these studies, three reported improvements in health equity outcomes or in the collaboration's ability to address health equity. They note improvements in breastfeeding outcomes among minority women and women on Medicaid, in self-reported health equity improvements, and in chronic disease management outcomes for children of low socioeconomic status.⁴

Discussion: Equity

Key Considerations — Pathways to Systems Equity

Our review suggests that the literature currently lacks information sufficient to make strong claims about how best to make large-scale system changes to improve population health

equity outcomes through collaboration. Many of the documents we reviewed point out that equity needs to be addressed, but they did not always provide more in-depth information.^{28,47,168,199,357} This finding is consistent with an earlier systematic review, which also found a gap in the collaboration literature concerning equity.³⁵⁸ Nevertheless, each theory of change component was linked to equity, so potential seems to exist for addressing equity through cross-sector alignment, even if most collaboratives have yet to document major changes in this area.

Key Considerations — Community Engagement and Equity

The literature shows that engaging the community is perceived as important for addressing equity. However, several questions remain. Does building community engagement into the front end (such as having community members hold leadership positions or evaluate programs) lead to outcomes that are more equitable? What does equity-producing community engagement look like? Can collaborations effectively address structural equity issues such as systemic racism? Can mandates for collaborative work addressing equity lead to better outcomes? Is this the best way to get sectors to address equity issues? In terms of research, it would be interesting to see a comparison of initiatives that required equity versus those that did not. Results from such research could be useful in practice as well.

Tensions

As we note above, a key objective for future research should be to identify and test pathways to systems equity — and ultimately, to health equity. Tensions in the literature reflect this lack of consensus regarding the best approach to tackling health equity.

One important tension involves the level at which equity should be addressed. Some studies suggest equity should be addressed at the policy level³⁴⁷ or that systemic inequities must be addressed before other solutions will be productive.³⁰⁶ Another suggests that equity should be addressed at the organizational level or within partnerships,²⁷² while still others suggest that addressing health equity is ultimately the responsibility of funders.^{67,115,343} As these divergent perspectives suggest, equity may be best addressed at multiple levels.

CONCLUSIONS

10 Observations

To summarize our review, we draw out the following 10 key observations:

1. Most of the literature we reviewed could be classified as theory building rather than theory testing. New analyses that account for context, that test competing theories, and that systematically compare collaboratives and alignments will both place research on firmer footing and provide practitioners with actionable insights.
2. While sectors are loosely discussed in the literature, relatively specific roles within alignment are discussed quite commonly. Often, these roles overlap. How this happens is an important question for the future. Importantly, the roles overlap across sectors. Thus, it might be helpful to understand the people involved in alignment in terms of both their sector and their role.
3. Various tensions emerge in the literature regarding core components of cross-sector alignment. Examples include the tension between action-orientation and patience, between striving for flexibility and seeking commitment, and between emphasizing structure versus highlighting leadership. These trade-offs, while not necessarily zero-sum, do suggest that implementing alignment may involve tough decisions about core components that will be optimal only in certain contexts.
4. The core components of cross-sector alignment also overlap. That is, they mutually reinforce each other in many ways, both in real time and over time. Accordingly, they could be understood not only linearly, but also cyclically.
5. If the goal is to move from cross-sector collaboratives to effective alignment that is built to last, then organizations should consider implementing change management to support iterative development of the core components.

6. Many (though not all) of the suggested structures and activities require resources. Sometimes the resource requirements are extensive. This means that in situations involving scarcity, more asset-based or less expensive approaches to aligning may be optimal. This does not mean that interested parties with fewer resources should avoid aligning. Rather, it again suggests that aligning may involve tough decisions and require the establishment of priorities that will be optimal only in certain contexts.
7. The complexity and potential for variation in collaborations and collaborative contexts suggests that alignment will emerge in different ways and face different challenges. It may make sense to try to formally and explicitly make sense of these different paths so that individuals and organizations wishing to align are aware of potential entry points and have tools to identify and address the most relevant challenges and opportunities.
8. A shared purpose is not necessarily a primary purpose. Partners join health-oriented collaboratives for many different reasons, and they each have a different set of priorities. While establishing shared purpose is an important process, it may also be important to develop a way to manage the distinct and divergent priorities of the collaborative partners.
9. Data and measurement systems can be complex. These systems are often underestimated in both a technical and an ethical sense when collaboratives are considering what might be necessary to achieve success. Even seemingly simple systems often require specialized skills for management and implementation. Paradoxically, this implies the use of both extremely simple and highly automated systems.
10. Equity, a key component of alignment outcomes, is closely linked to community voice. However, while many studies emphasize the importance of community voice, the literature has yet to elaborate best practices for prioritizing community voice. Establishing these practices will likely require changes in very large social and bureaucratic systems, but several collaboratives have already demonstrated successes with bold initiatives that empower community voice.

Limitations

This review has several limitations. Four in particular could and should be addressed in the future:

- We accounted for the strength of evidence by coding for whether or not the included papers contained analyses that systematically compared observations. This helped us establish that the vast majority of studies we reviewed classify as “theory building” (457 studies) rather than “theory testing” (114 studies). To create a firmer foundation for the field, it would be particularly helpful if future studies expanded the theory-testing side of the literature.
- The complexity involved in cross-sector collaboration suggests that researchers hoping to understand and inform practice should consider context wherever possible. Deeper dives into the existing literature’s specific subcomponents might help this effort, as might new studies that are context-conscious.
- In conducting this review, it became apparent that few studies have tied their work to existing theory. As a result, the findings often seem disconnected, and the implementations often appear to be trial-and-error. While this is normal for an emerging field, the literature on health-oriented cross-sector collaboration could be connected to other fields’ existing literatures fairly easily. This, too, would place research and practice on firmer ground.
- Finally, the theory of change contains several key elements that we did not focus on in this review. Capacity and urgency are prime examples. These items could be addressed in greater depth with time. Furthermore, while this review did focus on key findings relevant to aligning, it did not include open coding of key results overall. This suggests that alternative means of understanding the health-oriented cross-sector collaboration literature may yet be uncovered.

Despite these limitations, our study offers a comprehensive coding of the literature on cross-sector alignment’s core components as well as unique synthetic findings that emerge only

when viewing the literature as a whole. While considerable work remains, our findings should help practitioners identify key decision opportunities. It should also help researchers take next steps toward understanding cross-sector alignment and other collaborative efforts that aim to engage communities and improve community health and health equity.

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CHAPTER THREE

A Rapid Realist Review of Research Proposals

Karen J. Minyard

Health care, public health, and social services are the complicated, entangled components of our transforming health system. Aligning Systems for Health focuses on understanding this complex, adaptive system and how these sectors can align to meet the goals and needs of individuals and communities. Rather than emphasizing trial and error, human intuition, and muddling through, Schon¹ suggests that we arm ourselves with information about *what actually works for whom in what circumstances*. He discusses this in relation to two very different extremes: the high, hard ground in which practitioners can effectively use research-based theory and technique, and a swampy lowland with situations that are confusing “messes” incapable of technical resolution.¹

Here, we aim for the former, providing details and findings from a realist examination of the 151 large research grant proposals we received for our Aligning Systems for Health project.

WHY A REALIST APPROACH?

Realist approaches recognize that change processes are complex, adaptive, and context-dependent, and that engagements and outcomes vary across sites and are unstable, nonlinear, and unpredictable. Using a realist approach allows us to make sense of complex social interventions. A realist review includes an examination of contexts, mechanisms, and outcomes (CMOs); it then makes sense of the CMO patterns. This allows us to understand and build theory around what works for whom, under what circumstances, and why.²

We received 151 proposal summaries in response to the November 2019 Aligning Systems for Health call for research proposals. These summaries are the content for our rapid realist synthesis, which illuminates the emerging field of cross-sector alignment and provides a window into the researchers’ thinking and theories of change.

THE METHOD

In examining the 151 research proposals, our principal investigators (PIs) were interested in understanding how applicants were interpreting research around cross-sector alignment.

The PIs coded each proposal summary for analysis. This coding included the realist components of CMOs as follows. *Context* includes the conditions in which interventions are

happening — that is, the setting; these conditions are further classified according to the four I's of context: individual, interpersonal, institutional, and infrastructure.³ Our context coding included population, disparity, and setting (programmatic, organization, locality, and state).

Mechanisms are the resources and human reasoning applied to the intervention, yet they are not always readily seen. The PIs coded the resource and reasoning mechanisms for alignment and health and well-being. Among the *outcomes* they found were direct impact, system impact, and leading vs. lagging measures. Such outcomes might be individual, group, organizational, or systemic.

Once the PIs coded the program summaries, they examined the coding for congruence. The outcome items related to health and well-being were varied; they therefore subdivided them into three categories: health and well-being, equity, and upstream social risk factors.

In terms of the original Cross-Sector Alignment Theory of Change, CMO alignment is roughly as follows:

- *Context* aligns with external and internal factors.
- *Mechanism* aligns with the resources of shared purpose, data, financing, and governance, as well as factors influencing success and community engagement (reasoning).
- *Outcomes* align with the theory of change outcomes.

The PIs first examined coded spreadsheets for patterns within CMOs; they then looked for patterns across CMOs. They mapped these CMO patterns to each of the four broad outcome areas (alignment, health and well-being, equity, and upstream social risk factors). They also identified CMO-specific examples.

The Findings

The most common contexts across proposals included initiatives considering disparities related to socioeconomic status, race, housing, and health. The most common population groups included people who were disadvantaged/vulnerable, underserved, children, and experiencing low income. These are high-level findings; the CMO patterns show context in more detail.

The PIs also explored patterns in both resource and reasoning mechanisms. The high-

level patterns in resource mechanisms were care coordination, financing and global budgeting, data sharing, integrated programming, and community health workers. The reasoning patterns included community building, community voice building, trust and trust building, power sharing, and coproduction (including codesign, colearning, and codevelopment).

The PIs looked at alignment as an outcome, which was described in terms of a focus on equity, cross-sector alignment, and/or better connections. Improvement in mental health and depression was another frequent outcome. In terms of the subcategories, 63% of outcomes focused on well-being, 25% on equity, and 12% on upstream social risk factors.

The PIs also examined the coded proposals for macro-level CMO patterns. In four comprehensive reviews, they examined patterns related to the four outcome categories of alignment, health and well-being, equity, and upstream social risk factors. Among these outcomes were cross-sector alignment, expanded capacity, and new policies and practices. The contexts related to the alignment outcome did not fall into categories or patterns, as the proposals covered various populations, disparities, and settings. This was also true in relation to the broad outcome of health and well-being. Here, the outcomes were focused on individual rather than community outcomes, and the reasoning mechanisms included engagement, resiliency, self-expression, self-agency, trust, and awareness.

The context for the macro CMO patterns related to upstream health was frequently the state level. The upstream outcomes included patterns of economic security, housing, and child well-being. Education was a frequent mechanism, as were policies to improve processes and decrease barriers. Other less-prominent mechanism patterns included using data, engaging the community, and establishing a fund for upstream health.

The equity outcome contexts were varied, but they fell into patterns related to population groups and geography. The most frequent population was maternal/child; other targeted populations included LGBTQ, individuals using emergency medical services, Native Indian, and people experiencing housing challenges. The contextual geography was frequently rural, but the PIs also found geographic patterns of midsized cities, large cities, hyperlocal areas, and states.

The equity outcomes included general equity, access for a specific population, and building a culture of health. Resource mechanisms included building community voice and supportive

technology and tools, while reasoning mechanisms included community engagement, community voice, power, and trust.

The PIs also identified specific CMO patterns, including the following two examples:

- With a focus on mothers and children in Southwest Puerto Rico (context), one quality-improvement process aimed to build community capacity in order to promote self-agency, community centering, and colearning (resource and reasoning mechanisms). The result was shared action and improved outcomes for newborns and their mothers (outcomes).
- The Maryland Total Cost of Care Project targeted disadvantaged individuals with low socioeconomic status (population and geographic context). The project focused on global budgeting, with payment incentives aimed at encouraging a population health perspective (resource and mindset mechanisms). The results included increased capacity, which led to general improvements in health and well-being (outcomes).

Discussion and Conclusions

The realist synthesis of the researchers' proposals helps us to understand how they are interpreting the research opportunity. It also provides information about their theories regarding aligning. One high-level insight is related to context: Researchers are exploring a variety of contexts related to both geography and population groups. They are seeing various types of outcomes including alignment and the three dimensions of health and well-being, equity, and upstream social risk factors. The researchers generally are not focused on community outcomes, but there was a hint of community focus in research projects targeting housing, building a culture of health, and policy. We also found a significant state-level context focus.

The examination of the mechanisms was perhaps most interesting and illuminates the researchers' theories about what will work for whom in what circumstances. Potential theory statements include the following:

- Across various contexts, community engagement and building resiliency, self-expression, self-agency, trust, and awareness will support health and well-being.

- At the state level, education programs, policies that decrease barriers and improve processes, funding, support for data, and community engagement will improve economic security, housing, and child well-being.
- Across various contexts, data and network sharing, programming resources, and education and training will support cross-sector alignment, expanded capacity, and new practices.
- In a variety of population and geographic contexts, community engagement, voice, power, and trust will support equity.

In the six months after receiving the research proposals, the Aligning Systems for Health team studied the literature, examined the work of other people in the field, and held numerous convenings and calls to examine the theory of change. From this, a framework emerged that affirmed the theory of change's four components: shared purpose, governance, shared data and measurement, and financing. The new Framework for Aligning Sectors recognizes the dynamism of these core components as well as emphasizing the importance of community voices, equity, power dynamics, and trust as adaptive factors intertwined with these components. The framework also includes proximal outcomes of changes in mindset, practice, and policy. As the framework emerged, it was not initially clear that its center box (core components and adaptive factors) described the mechanisms of aligning.

The findings from the rapid realist synthesis foreshadowed this new framework. Each of the core components appears in the analysis in some way:

- Financing was recognized as a resource mechanism to support alignment and equity.
- Data was recognized as a resource mechanism for alignment, improved health, and addressing upstream social risk factors.
- Involving community members in governance and defining purpose was a mechanism in all health and well-being outcomes.

Further, all of the adaptive factors — community voice, power, trust, and equity — are prominent in the mechanism patterns impacting health and well-being. Although we knew the realist synthesis of the proposal summaries would be helpful, it was only in reflecting on it that we recognized the power and comprehensiveness of its findings.

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CHAPTER FOUR

Aligning in Action: Lessons from
Community-Based Efforts

The Aligning Systems
for Health Research Team

Health is impacted by factors beyond the health care delivery system, including housing, education, poverty, employment, food availability, transportation, and safety. Recognizing that we must address these social determinants of health (SDoH) to meaningfully impact health inequities, a national policy shift is now taking place as government agencies, payers, and providers consider adopting an SDoH perspective.

In response to this shift, Aligning Systems for Health is learning from stakeholders across the nation about effective ways to align the health care, public health, and social services sectors to better meet people's goals and needs.

As part of its research effort to compile alignment information, the Aligning Systems for Health team reviewed and synthesized learnings about cross-sector alignment from key documents, briefs, case studies, interviews, and structured feedback, as well as the experience of catalysts, researchers, and funders who have been involved with cross-sector alignment efforts.

We identified 16 communities across the country involved in work that aligns systems across the health care, public health, and social services sectors. We then studied these community efforts to better understand common issues related to the main components of the Cross-Sector Alignment Theory of Change (now the Framework for Aligning Sectors). The framework's four core components are purpose, governance, data, and sustainable financing mechanisms.

This chapter presents the stories of the collaborations and lessons learned in these 16 communities as they work to align the three service sectors. As their stories show, there is not a single best practice of partnering, governing, financing, and implementing; instead, there are a variety of approaches for bringing together and aligning diverse partners who have a common goal of improving health, safety, and well-being.

THE FOUR COMPONENTS IN ACTION

Although there is no single model or formula to align systems, the stories in this chapter provide insights and learning from stakeholders who are actively working to align the three sectors. Best practices occur in a variety of settings, from local public health departments to regional collaboratives to housing organizations to health care systems. The organizations are located in rural and urban communities across the United States, from Florida to Oregon.

Purpose

The communities came together for different purposes. Some wanted to address specific inequities identified through their community needs assessments or other data-gathering tools and analytics. Some were focused on program-specific areas such as behavioral health, improved health for children, and housing, while others responded to government policies and grants. Some of the organizations leading the efforts were already established, such as public health departments, hospitals, housing associations, and foundations; others resulted from a variety of diverse partners forming collaboratives to address the issues. All of the participating organizations expressed a desire to be inclusive of the broader community beyond health, and to connect, communicate, and coordinate their efforts.

Governance

To effectively address their identified needs and goals, successful collaborations work across the three sectors and through a variety of governance and administrative arrangements. Some operate under the oversight of a government entity, others are governed by nonprofit boards, while still others are led by loosely knit committees convened for a specific purpose. The collaboratives also use a variety of administrative structures to provide backbone support and manage the work.

Data

An important factor influencing much of the learnings from these cases was the quality and quantity of data that each location has collected, analyzed, and transmitted. Many of the communities have sophisticated health information technology and exchanges (dashboards, resource hubs, and other systems) that provide information and analysis for collective sense making on disparities, enhanced alignment, and established metrics, trackings, referrals, and so on.

Sustainable Financing Mechanisms

As with many community initiatives, identifying sustainable funding is a challenge. The

organizations use various financing mechanisms, including local, state, and federal government programs and grants (including Medicaid waivers); philanthropy; nonprofit and corporate organization contributions; and wellness funds, hospitals, and contracts paying for specific operations and products such as screenings and data provision and analysis.

COMMON THEMES AND LEARNINGS

Although the 16 alignment communities have differing approaches to shared purpose, governance, data, and financing, common themes and learnings emerge that highlight several factors that are crucial to consider when aligning across sectors.

Prioritize Meaningful Community Engagement

Participation includes being at the table and having skin in the game. Community engagement must be genuine — not merely a seat at the table, but a true partnership with shared power. For example, HealthierHere supports community members and community-based organizations with resources to ensure they have the capacity to be at the table. An important component of the Atlanta Regional Collaborative for Health Improvement (ARCHI) engagement strategy is to have “zero barriers to entry,” while Palm Health’s steering committee is a balance of 50% lived leaders and 50% learned experts. The Community Caring Collaborative measures its success by the extent to which its 65 partners choose to invest their time, energy, and resources (salary) to participate in their convenings. Healthy Homes Des Moines notes that if it had had someone at the table who had something financially to gain, its initiative would have been more successful. Live Well San Diego calls the voice of the resident the “secret sauce” in its success and says it empowers community residents by providing tools, training, and data to help them be more knowledgeable and engaged.

Integrate Equity Throughout

The role of equity must be integral to the process, not merely an end point. When trying to

achieve racial and health equity, organizations must pay heightened attention to how stakeholders navigate power dynamics. That is, to get things done, meaningful engagement of community voices in a cross-sector collaborative requires recognizing that everyone has value and that the experience of others counts.

Shared progress toward meeting communities' goals and needs, health equity, and racial equity does not happen right away. First, there must be changes in mindsets, practices, and policies to support the more distal outcomes. Having the right mindset is central to participating in challenging conversations, reflecting deeply, and re-envisioning communities.

Palm Health supported one of its communities that chose behavioral health as an area of focus, and involved the community in a Race Equity Institute workshop as part of the conversations about tackling behavioral health. HealthierHere used some of its waiver dollars to fund infrastructure and capacity of social service agencies when it determined that many of these agencies are significantly under-resourced and do not have the capacity they need to begin discussions and develop new partnerships with the health care system.

Balance Structure and Flexibility

Adaptability and flexibility are often needed to work through the complexities involved in cross-sector partnerships. Community voices, trust, equity, and power dynamics (both between sectors and between the sectors and community members) are integral to adapting the four core components to address local needs. Palm Health suggests that leadership must be comfortable and flexible with the messiness involved in cross-sector alignment. That is, organizations must strike a balance between adhering to the established structure and following the direction of the energy, continually paying attention to feedback.

Target Sustainability

Some multistakeholder collaborative efforts are temporary due to funding constraints, lack of incentives, and structures that don't facilitate more permanent connections. For the 16

communities here, long-term sustainability is a goal. Several, however, expressed concern about the resources required to continue and build on their efforts. Alignment requires real change so that joint efforts to improve health and health equity among health care, public health, and community-based social services can endure.

The Plan for a Healthier Allegheny is an example of a cross-sector partnership that is built to last beyond one-off grant opportunities. Live Well San Diego found that organizations that were too grant-centric can be cut, but an integrated vision that the entire budget supports is sustainable.

Aligning sectors and systems is a way to sustain the impact of collaborative efforts. The Northwest Ohio Pathways Hub is an example of aligning with payers, which produces a sustainable funding stream for much-needed services. Colorado's Rocky Mountain Health Plans has found that a key for financial sustainability is to demonstrate value by connecting patients to social services and resources. Yamhill Community Care Organization has developed a system to take revenues from inactive payments tied to reaching quality metrics and direct them back into the community to implement upstream population health interventions.

Learn from Data

Data collection, analysis, translation, and sharing are key factors in identifying disparities and creating effective cross-sector partnerships. To strengthen its cross-sector approach, Gen-H uses data to conduct a gap analysis, prioritize the health-related social needs to address, and engage neighborhoods in developing community health dashboards. Palm Health, through its data collection and collective sense-making systems, uses data to elevate the voices of those with lived experience. The Michigan Health Improvement Alliance invested effort and resources into building a data platform that now serves as a tool for both the collaborative and the public. NCCARE360 uses collected data to quantify the social network and social needs.

Take the Time to Develop Trust

Trust-building is a clear ingredient for success, but developing it among partners takes time. Parkland Center for Clinical Innovation suggests starting small and growing trust in measured steps. Vita Health and Wellness believes that decades of building trust and relationships are central

to the success of its program. The Western Idaho Community Health Collaborative learned that trust established over several years served the group well in expanding broadband during the COVID-19 pandemic. ARCHI's 28-year time frame acknowledges and plans for the generational nature of the challenges it is attempting to overcome.

A GUIDE FOR FUTURE EFFORTS

As these stories illustrate, when health care, public health, and social sectors align in new and different ways, they are more accountable to the goals and needs of the individuals and communities they serve.

The findings from this research can both continue to guide the current communities involved and provide a road map for other communities, researchers, and funders to follow as they work together to align these sectors to improve health, safety, and well-being in their communities, especially among the populations most at risk of inequities.

ALIGNING IN ACTION

ALLEGHENY COUNTY HEALTH DEPARTMENT



The Allegheny County Health Department serves as the backbone organization that aligns the efforts of a large, multisectoral collaborative focused on implementing the county's Plan for a Healthier Allegheny (PHA).



Lead organization: Plan for a Healthier Allegheny Advisory Coalition, led by the Allegheny County Health Department

Lead sector: Public health

Location: Allegheny County (Pittsburgh), Pennsylvania

Year founded: 2015

Interviewees: Karen Hacker, former director, Allegheny County Health Department, and Alaina Conner, special projects program manager, Allegheny County Health Department

LOCAL CONTEXT

The Allegheny County Health Department convenes a large coalition of health care and social service organizations. As such, it follows the Public Health 3.0 model (www.cdc.gov/pcd/issues/2017/17_0017.htm), which calls for local health departments to engage multiple sectors and community partners to collectively address social, environmental, and economic conditions that affect health and health equity.

The Advisory Coalition uses the PHA as its road map for improving the county's health. It adopts a Health in All Policies perspective to engage diverse partners in collectively working toward a healthier community — one that allows all citizens to maximize their quality of life and well-being. Among the many coalition partners are the Port Authority of Allegheny County, Uber, the Allegheny County Department of Economic Development, the YMCA, and the Greater Pittsburgh Community Food Bank.

SHARED VISION

The PHA emerged from the county's 2015 community health needs assessment; it thus grounds all coalition partners in a health- and well-being–related perspective and serves as a road map for action. The PHA has five priority areas: access to health care, chronic disease health-risk behaviors, environment, maternal and child health, and mental health and substance abuse. Each area has its own objectives, metrics, and actionable strategies that require broad community participation for progress and rely on commitments from health care providers, social service agencies and organizations, and community-based organizations.

DATA MEASUREMENT

To give coalition partners and other interested parties access to data on various public health topics, the Allegheny County Health Department launched the interactive Allegheny Community Indicators Dashboard. This publicly available dashboard lets users examine the data from Allegheny County and its municipalities, neighborhoods, ZIP codes, and census tracts and compare it with data from other counties, as well as with data on state and national health (including Healthy People 2020 goals).

The county developed the dashboard in conjunction with the Healthy Communities Institute and used aggregate data from nearly 30 sources. Available searches include demographic information, health indicators, and health disparities; the dashboard also offers curated resources to help users find promising practices and available grants.

Allegheny County measures progress toward its priority outcomes using the PHA's initial metrics, which were further refined by work groups focused on key priorities.

FINANCING MECHANISMS

The Public Health Improvement Fund is a philanthropic collaboration and a blended distribution fund of the Pittsburgh Foundation that flexibly supports the Allegheny County Health Department leadership in developing and strengthening its capacity and activities.

Initial Public Health Improvement Fund investments enabled the community health assessment that informed the PHA. Subsequently, in 2016, the fund's mission was expanded to fund innovative public health projects addressing the needs identified in the PHA. The health department's leaders apply for the funding and manage projects as they partner with other organizations.

In addition to the Public Health Improvement Fund, the PHA Advisory Coalition partners have successfully applied for other grants — including from the Centers for Disease Control and Prevention and the BUILD Health Challenge — to fund their multisector efforts.

GOVERNANCE STRUCTURE

According to Karen Hacker, former director of the county's health department, the Allegheny community feels that the department, as a public agency, should be bringing people together. In keeping with this vision, the PHA Advisory Coalition collaboratively developed the PHA, which has grown to include more than 100 organizations.

The coalition also established working groups around each priority area. These groups have identified gaps in existing work, built on existing community efforts, shaped innovative and

collaborative interventions, and created momentum to improve the health of Allegheny County. The work groups have also successfully connected various partners that subsequently applied for grants to further the work. Each work group is cochaired by a health department representative and a representative of a coalition partner.

INSIGHTS FROM THE COLLABORATIVE

It takes time to develop meaningful, cross-sector relationships in any community. By establishing trust through the Allegheny County Health Department's PHA, the community was primed to respond quickly and effectively to emerging issues and to demonstrate the requisite relationships for successful grant applications. In Allegheny County, external pressure — in the form of government commitment and significant public investment — helps to bring issues into the public arena, generate interest, and engage multisector partners in creating action or change. Alaina Conner, the health department's special projects program manager, notes that public accountability is critical; without it, initiatives easily fall off the radar.

ALIGNING IN ACTION

In 2016, childhood lead exposure became a flashpoint issue for public discussion. Although the PHA had not identified lead as a priority issue, the health department and its cross-sector partners in the PHA coalition quickly sprang into action.

Allegheny County residents are particularly vulnerable to lead exposure due to aging infrastructure, especially in housing. More than 80% of the Allegheny County homes were built before 1978, and half of those homes were built before 1950. In children, no level of lead exposure is safe; even low levels have been associated with cognitive and behavioral issues. Further, children under six years of age are at the highest risk for absorbing lead from their environment and are the most susceptible to lead absorption's long-term harms.

In 2017, the increased public interest in reducing lead exposure hazards helped the Allegheny County's Board of Health and County Council pass a local universal lead screening ordinance — the first in Pennsylvania. In 2018, more than 23,700 children were tested. The Allegheny County chief executive also commissioned a lead task force that produced recommendations in December

2017 and issued its first annual lead report in 2018.

To address the task force recommendations, the Allegheny County Health Department partnered with numerous local and state organizations to begin dealing with lead exposure hazards in the following ways:

- **Surveillance.** The department tracks data on lead exposure and monitors children's elevated blood lead levels in real time by extracting data from the Pennsylvania National Electronic Disease Surveillance System. The health department also offers free lead testing for the uninsured or underinsured.
- **Prevention and education.** The health department launched a Get Ahead of Lead campaign and funded 10 community organizations to help with its education effort, especially in higher-risk communities. The partners included Circles of Greater Pittsburgh — Mon Valley, Clairton Cares, Consumer Health Coalition, Environmental Occupational & Public Health Consultants, Homewood Children's Village, Perry Hilltop Citizens Council, Pittsburgh Learning Commons, United Somali Bantu Community of Greater Pittsburgh, Women for a Healthy Environment, and Youth Enrichment Services.
- **Intervention.** The Safe and Healthy Homes Program (SHHP) is available to anyone who meets income requirements and has either a pregnant woman or a child under 22 years of age residing in the home. SHHP provides free in-home health and safety assessments to qualified participants in Allegheny, Beaver, Washington, and Westmoreland counties. Further, free inspections to identify sources of lead exposure are offered for homes with children under 6 years of age who have a confirmed blood lead level of 5 µg/dl or more.
- **Community-driven leadership.** As the public's focus on lead increased, a coalition of community partners emerged, many of whom had been involved in the PHA. In 2018, the health department and the local Women for a Healthy Environment advocacy organization received funding from the National Centers for Healthy Housing to support staffing of a reconstituted community-driven lead advisory coalition. With leadership from Women for a Healthy Environment, the coalition takes a Health in All Policies approach to addressing lead issues in the county.

INSIGHTS FOR ALIGNING

- The PHA Advisory Coalition is an example of a cross-sector partnership that is built to last beyond one-off grant opportunities.
- Allegheny County's community health needs assessment created a common purpose.
- External factors — such as high lead exposure rates — focused the coalition on opportunistic cross-sector opportunities.
- Public accountability helps ensure success.

ALIGNING IN ACTION

ATLANTA REGIONAL COLLABORATIVE FOR HEALTH IMPROVEMENT



The Atlanta Regional Collaborative for Health Improvement (ARCHI) uses a collective impact approach to reduce health disparities and create place-based systems change. ARCHI's goal is to build a healthy population living in a vibrant economy in the metropolitan Atlanta area, giving all citizens an equal opportunity for well-being.



Lead organization: Atlanta Regional Collaborative for Health Improvement (ARCHI)

Lead sector: Neutral backbone organization

Location: Atlanta, Georgia

Year founded: 2011

Interviewee: Kathryn Lawler, ARCHI executive director

LOCAL CONTEXT

As in other major cities, in Atlanta, a person's ZIP code is often the biggest predictor of his or her health status, with a few miles making a 13-year difference in life expectancy. In 2011, 12 Atlanta leaders convened to discuss how hospital community-benefit efforts and collective impact could be used to address the city's health disparities, which led to the creation of ARCHI.¹

ARCHI's three founding organizations — United Way, the Georgia Health Policy Center, and the Atlanta Regional Commission — brought their philanthropic, convener, and regional planner hats to what was a cross-sector effort from the beginning. Using a collective impact approach, ARCHI offers backbone support by providing a neutral platform, incentivizing unlikely partners, activating innovative models, and demonstrating mutual benefit with the goal of accelerating health and economic improvements.

SHARED VISION

More than 110 member organizations from across the health care, public health, and social services sectors, as well as government, housing, business, philanthropy, and transportation, made a formal commitment to supporting ARCHI's long-term strategy.

ARCHI adopted its 28-year strategy for health improvement in 2012 based on an interactive modeling exercise facilitated by the Rippel Foundation and ReThink Health. By exploring short- and long-term impacts of various intervention and investment strategies, the model allowed ARCHI to explore changes to clinical care, expansion of access to care, innovations in financing, and upstream investments in education, economic opportunities, and behavior change.

The foundation of ARCHI's agenda is the Atlanta Transformation scenario, which focuses on seven core strategies: care coordination, capture and reinvest, expanding insurance, family pathways, healthy behaviors, global payment, and an innovation fund.

The ARCHI partners engage along a spectrum of deepening commitment to enacting the 28-

¹ Minyard, K., Lawler, K., Fuller, E., Wilson, M. & Henry, E. (2016, Spring). Reducing health disparities in Atlanta. *Stanford Social Innovation Review*. https://ssir.org/articles/entry/reducing_health_disparities_in_atlanta

year strategy. At the most basic level, partners engage around shared learning, which in the pre-COVID-19 days centered on quarterly breakfasts exploring topics broadly related to health equity (e.g., health and housing, homelessness). These breakfasts provided an opportunity for relevant learning and networking. At the far end of the engagement spectrum, ARCHI partners come together in action around prototype or pilot projects.

“The efforts need multiple parties to absorb the risks to be successful,” explains Kathryn Lawler, ARCHI’s executive director. “We are there at the table providing design support, best practice research, and then, in some instances, actually helping do the fundraising and the project management.”

ARCHI staff often temporarily run the day-to-day operations of these multipartner projects until there is an evidence base and plan to sustain the program in the community.

ARCHI partners remain committed to aligning their organizational efforts around the Atlanta Transformation’s seven core strategies. However, an annual strategy session with the ARCHI steering committee revisits priorities based on evaluation, accountability, and measurement milestones, so within these core strategies, the priorities of ARCHI’s backbone work may shift.

“In the past, we treated all seven equally, but over the past two years, the steering committee placed greater emphasis on care coordination over finance reforms,” says Lawler. “We consulted with others and every one of the economists that we met with all agreed that these finance reforms are still really good ideas, but that they should be put into hibernation mode until the broader external environment reprioritizes them again.”

Lawler adds that with the COVID-19 pandemic, there was re-energization and excitement for collaborative work on care coordination, with an emerging willingness to work together that ARCHI “could have only dreamed of in the past.”

DATA MEASUREMENT

ARCHI analyzes partner engagement on a monthly basis and over time across the engagement spectrum. How many people attended a learning session? How many introductions did ARCHI facilitate? How many new partnership inquiries have been received? How many people are working on a live, ARCHI-facilitated project?

Each prototype or pilot project also has metrics that it tracks. For example, the Community Resource Hubs, which enable rapid referrals between clinical providers and community-based social service organizations, are sharing real-time data across organizations. As we describe later in the “Aligning in Action” section, Lawler says that the initiative enables participating organizations to see, for example, that Ms. Jones has been referred for job counseling and benefits analysis, enabling a community health worker at a participating Federally Qualified Health Center to make an appointment at First Step Staffing, which can then report back that Ms. Jones showed up and had a great appointment, and provide next steps. At the end of the program enrollment, the Community Resource Hubs will have the metrics to show how improvements in meeting Ms. Jones’ social needs impacted her health outcomes.

FINANCING MECHANISMS

Funding for ARCHI has evolved over time. Initially, the three organizations represented in the executive leadership groups provided considerable in-kind support, and steering committee members all contributed to core funding.

Lawler credits the initial multiyear funding as helpful to getting ARCHI started. Now, a core set of collaborative funders support operations on an annual basis, and a much greater percentage of ARCHI’s budget is driven by project work. Funding partners vary by project; they have included private corporations, philanthropy, and government sources.

“From day one of projects, we are always talking about where it’s going to live, and that’s an important part of building the financial sustainability strategy,” says Lawler.

GOVERNANCE STRUCTURE

The Atlanta leaders that convened in 2011 became the core of the 15-member ARCHI steering committee, which includes representatives of area hospitals, insurers, state and local public health agencies, behavioral health providers, the U.S. Centers for Disease Control and Prevention, educators, and community members. Representatives of the founding organizations — United Way, the Georgia Health Policy Center, and the Atlanta Regional Commission — constitute the

three-member executive leadership team that provides strategic direction for the collaborative as well as ongoing staff support.

ARCHI also supports several advisory groups, including community advisers. Lawler explains that incorporating community voice is key and that the goal is to move community participation from project-based decision-making to a more prominent role in overall strategy.

“When projects are in design mode, as well as in implementation, we enlist certain individuals or community members to be stipend advisers to the project because everybody else is at the table because they’re getting paid, so we are not asking people to volunteer,” Lawler says.

Each prototype or pilot project has its own governance structure. It starts with design work, which incorporates diverse input and community representation from a particular neighborhood or patient group.

“If we pull the trigger on implementation, then the decision-makers become those with skin in the game, and that’s really about the money and resources,” says Lawler. “Others involved in the design can remain advisers.”

INSIGHTS FROM THE COLLABORATIVE

Part of ARCHI’s engagement strategy is to have “zero barriers to entry” in order to overcome the initial discomfort that some people feel when collaborating beyond their day-to-day work sector.

“It always amazes me how everybody thinks everybody else’s work must be so impossible to understand,” says Lawler. “Housing thinks, ‘Oh, we could never understand health care.’ That gap between them, whether it’s language or comfort, everybody thinks everybody else’s work is rocket science. Translating across sectors and helping people see the Venn diagram where there is overlapping space is, I think, a real value proposition ARCHI brings for others.” Lawler says a diverse value proposition has been critical to keeping all of ARCHI’s diverse players at the table.

“There just continues to be a desire in a very competitive world of health care to have a neutral place,” she says. “And then part of our job is to go through ARCHI partners and stay up-to-date on their work and help facilitate those connections, not just among competitors, but among people and organizations that may not know each other. We are there knitting people together,

making it a more efficient process when there is an ‘aha’ moment and health care wants to connect with social services. We can make that happen really quickly and easily for folks. And then they can be off to the races.”

ARCHI’s value is in providing a neutral space for connecting, serving as a translator, and, lastly, absorbing the risk of trying something new.

“When we talk about aligning health care, and public health, and social services, the immediate risk is that we’re asking people to do things for which they’re not being measured,” says Lawler. “We are asking them to work in a way and do things that they’re not being measured on. And when you’re not being measured on it, it means it’s not valued by your organization. And that’s extremely risky, even if you know it needs to be done. So, ARCHI is holding the innovation and the in-between time to see, is this really going to work?”

Bringing both competitors and diverse partners together boils down to relationships.

“Before ARCHI was ARCHI, people kept coming to talk because we all knew each other. We didn’t know what exactly we were going to do together, but the relationships were enough to stay at the table and keep going until we figured it out,” recalls Lawler, adding that the same dynamic played out again early in the pandemic. “We didn’t know exactly what we were doing, but people joined in with us because it was ARCHI and because we asked them to.”

ALIGNING IN ACTION

ARCHI partners recognized that patients have difficulty navigating and receiving social services that can address the root causes of their health challenges.

In 2018, ARCHI convened a small working group representing health care and social service providers, payers, and funders to address this barrier to person-centered care. After extensive discussion, research, and learnings from national leaders in this field, the group committed to building a real-time, rapid-referral network (the Community Resource Hub) enabled by real-time data-sharing among clinical providers and community-based social service organizations.

The Community Resource Hub pilot is based at Grady Memorial Health System, the city’s safety net hospital, and Mercy Care’s Decatur Street clinic, a Federally Qualified Health Center. Grounded in a patient-centered model, the Community Resource Hub is a real-time, rapid-referral network with coaching support and data-sharing among clinical providers and community-based social services. The hub’s central premise is that inverting the burden of navigating social services from the patient to the system itself — via community health workers and strong relationships among agencies and providers — will improve community health.

The hub targets high-need patient populations at both of the health systems, focusing on the social needs of housing, nutrition, employment, income, and transportation. At each location, a community health worker serves 50 patients at any given time.

“Previously, a job training agency could say important things, like, ‘We helped this many people get work, wages increased,’” says Lawler. “But now they will be able to report, ‘and her diabetes went down, and her hypertension got under control, and she got housing.’ That is an impact story versus a service-delivery story.”

ALIGNING DURING COVID-19

In early 2020, ARCHI decided that given the federal policy environment, its value-based payment project was not progressing after two years of design and could not move into the implementation phase because it lacked a funder.

“Literally, at the start of 2020, we decided it is a good cause, we did accomplish a lot, but that this project needed to go back on the shelf. So, we were designing an evaluation and that was what was going to come of it in 2020,” recalls Lawler. “But a couple of weeks into the COVID-19 pandemic, when we realized this was going to last a long time, we got these same hospitals back together to discuss the issue of discharging COVID-positive, homeless people back to the streets. What was amazing was we had all the phone numbers of all the right people from the value-based project, and within a day, we could put that call together to address something totally different.”

INSIGHTS FOR ALIGNING

- ARCHI's use of a 28-year strategy emphasizes the generational nature of the challenges they are attempting to overcome.
- Elinor Ostrom's eight principles of self-governance provide a road map for how health care, public health, and social services might hold each other accountable to communities.
- ARCHI's engagement strategy of zero barriers to entry is useful for showing how collaboratives might be more inclusive of cross-sector organizations.

ALIGNING IN ACTION

THE COMMUNITY CARING COLLABORATIVE



The Community Caring Collaborative (CCC) has become the backbone organization for regional efforts to holistically improve the health and lives of community members in Maine’s Washington County. CCC convenes and supports partners in incubating effective and collective programming aimed at responding to shared regional challenges. With a goal of enabling deeper, authentic collaboration, CCC measures its impact by improving alignment across sectors and agencies to ultimately improve the lives of Washington County residents.



Lead organization: Community Caring Collaborative (CCC)

Lead sector: Social Services

Location: Washington County, Maine

Year founded: 2007

Interviewee: Julie Redding, clinical director, CCC

LOCAL CONTEXT

Washington County is the nation’s easternmost county and one of the oldest in Maine. The region’s population and economy are in decline, and it is a hot spot for the opioid epidemic. More than a decade ago, county leaders noticed that a growing portion of county births were impacted by substance exposure. The closest neonatal intensive care unit for drug-affected babies was two hours away, however, and travel to it was compromised in the long winter months by weather and treacherous roads. These transportation and logistical issues were compounded by the absence of a support network and collaborative medical care to address the unmet social and emotional needs of mothers and their infants; in addition to stigma and blame, they faced challenges with healthy attachment and parental bonding.

Recognizing the long-term downstream health effects of the opioid crisis on this fragile region, multisector leaders came together to respond with an immediate focus on at-risk infants, young children, and their families. The goal was to build a more cohesive system of care that could provide wraparound support. Realizing that no single agency could do it alone, CCC was launched and went on to overcome a history of distrust and competition in a region with scant funding and tremendous need.

SHARED VISION

The foundational expertise in CCC focused on client-centered, strength-based behavioral health treatment. Because the collaborative’s leaders recognized the value of existing local organizations, they applied their client- and strength-based approaches to supporting them.

CCC’s shared vision has evolved from responding to an opioid-related emergency to taking thoughtful, planned actions aimed at strengthening the region by strengthening the relationships, abilities, and capabilities of local nonprofits to build a healthy, well-functioning Washington County.

“CCC did not need to be a doer but can support the doers to be excellent doers,” explains Julie Redding, clinical director of CCC. “There are ways in which we can enrich the opportunities, knowledge, skills, and training that our providers need, which can take us to that next level to

really build grassroots initiatives that fill the gaps in services or support.”

CCC furthers these goals through its annual Vision Day, where multisector stakeholders come together to envision the county they wish to live in, without fiscal constraints. CCC listens and incorporates stakeholders’ on-the-ground needs into proactive planning for action that fills identified gaps. The event also further removes barriers between organizations and agencies so that they can work together to change service quality and outcomes for Washington County residents.

“We are an entity that is able to think about the health and well-being of the providers in the area, and if we take care of them, they might be able to build more internal resilience to be able to better support the community members and individuals of Washington County,” says Redding.

DATA MEASUREMENT

CCC measures its success by the degree to which partners invest their time, energy, and resources (in terms of salary) to participate in convening. To date, membership has reached 65 partner organizations with representation at the county, state, federal, and tribal levels.

Growth and success are also measured by the number of programs and initiatives that CCC supports or participates in. “For us, the real wins are the degree to which we have seen partners, service providers in the area, go from barely speaking — literally not even referring to another agency because of old wounds or old hurts — to now sharing contracts and sharing funds,” says Redding.

CCC supports agency partners in delivering coordinated, aligned programming aimed at shared goals — such as reducing poverty or increasing workforce participation — that ultimately aim to improve individual, family, and population-level outcomes.

FINANCING MECHANISMS

Rather than chase dollars, from its inception CCC has sought to conceptualize programs based on identified needs, and then search for funding to maintain program integrity.

CCC’s early funding came via a five-year grant from the federal Substance Abuse and Mental Health Services Administration’s Linking Actions for Unmet Needs in Children’s Health.

This funding helped CCC realize its Bridging Model concept.

To date, CCC's funding has been a mix of foundation dollars and grants, state and federal grants, and state contracts. Its core, ongoing mission is twofold: to provide learning opportunities (training and technical assistance) for its partners and to provide flexible funds for new and existing programs that address financial barriers for their client families as they work toward success.

With uncertain funding, CCC remains nimble in order to create opportunities based on identified community needs. It secures funding, incubates new programs, plans for sustainability, and ultimately moves successful, ongoing programs to host organizations. To plan for its own sustainability, CCC remains extremely lean and responsive.

“No one is coming from away to fix this for us,” says Redding. “There is not going to be an economic boom by some multinational company coming to town that's going to save us all. CCC has always worked hard to find funding to make sure that our partners can come to trainings at no cost or at very, very, very minimal cost.”

GOVERNANCE STRUCTURE

Rather than exist as an independent 501(c)(3), CCC instead made the strategic choice to have a local fiscal sponsor. Further, CCC does not have a board of directors, and it maintains a lean operation. It serves as a convener, hosting monthly meetings for direct service-level providers, including front-line workers such as case managers, therapists, home visitors, public health nurses, and child welfare workers. It also holds a separate convening for agency and area directors and CEOs. These ongoing stakeholder meetings function as an informal advisory council, identifying priority areas in a grassroots way. Focus groups — which include consumer voices — are convened at the start of new projects and held continually for quality improvement.

“This is how programs present themselves. It is really about listening for the challenges and then saying, ‘OK, who do we have for experts around the table?’” explains Redding. “We see what our partners have an appetite for, and then we do a lot of the backbone legwork in convening folks, bringing in experts, bringing in training opportunities, and often establishing subcommittees or special work groups to vet and think about some ideas.”

INSIGHTS FROM THE COLLABORATIVE

Given the region’s history of distrust and failed collaborative efforts, Redding credits time in the room together as crucial for building authentic relationships.

“CCC provides the platform for convening,” says Redding. “We set this table and we invite folks to come to the table, but the degree to which they are able to show up at that table is really up to them. They are more apt to have conversations with their neighbors at that table. They’re more apt to develop true relationships — true friendships, even. That level of trust and communication is built and then strengthened and reinforced.”

CCC also views common language as key to ensuring similar knowledge content and shared values across the sectors. Being informed about trauma, poverty, and substance use, as well as being culturally competent, is relevant for working with the population; it is also the foundation for working together across organizations.

ALIGNING IN ACTION

CCC designed the Washington County Nurse Bridging Program to support families who have infants or young children with multiple needs (medical or developmental) and women with high-risk pregnancies, including substance-affected ones. The program is delivered by registered nurses who are trained infant and family support specialists and staff members of CCC partner agencies.

The program offers various forms of support:

- Services-related support, education, and advocacy
- Wraparound planning emphasizing family-driven, strengths-based supports
- Development of individualized plans with a family team
- Access to home visiting programs, nursing supports, occupational therapy, speech therapy, physical therapy, assessment, developmental therapy, family support services, and parent education

- Identification of natural supports that can help the family and child achieve their goals

Support specialists can also visit and support the parents and children in the hospital, accompany parents to meetings with doctors or other direct service providers, and help the children and family navigate across multiple systems to improve outcomes. Services continue for as long as they are needed, and referrals can be made by local providers, parents, or CCC partner agencies.

The model — which shows promise nationally — has been identified by the state of Maine for statewide replicability to support babies born with neonatal abstinence syndrome; this support includes the delivery of babies by CCC-trained health and home-visiting professionals.

Maine has also identified several of CCC's collaboratively incubated programs, including Nurse Bridging, as having potential for statewide replication based on their strong results for early childhood, health, and family economic stability.

INSIGHTS FOR ALIGNING

- CCC arose out of the urgency surrounding the opioid crisis's impact on at-risk infants
- CCC provides the multisector effort's internal capacity, including backbone support, leadership, flex funds, and skills training.
- Through its annual Vision Day, CCC incorporates the insights of community stakeholders to create a common purpose that supersedes any one organization's purpose.
- Trust-building, through time spent together, is a key ingredient in CCC's success.

ALIGNING IN ACTION

GEN-H



Gen-H is a long-term systems-change initiative that strives to make Greater Cincinnati and Northern Kentucky a healthier, more vibrant region by addressing unmet health-related social needs. With multisector partners at the table from the start, the initiative uses the Accountable Health Communities (AHC) model as a way to address health-related social needs.



Lead organization: Gen-H at the Health Collaborative

Lead sector: Health care

Location: 14 counties in Southwest Ohio, Southeast Indiana, and Northern Kentucky

Year founded: 2014

Interviewee: Kiana Trabue, executive director, population health strategies

LOCAL CONTEXT

In 2015, three nonprofits — the Greater Cincinnati Health Council, HealthBridge, and the Health Collaborative — merged under the latter’s name to align their services and more efficiently meet the needs of the members and communities they serve. Premerger, the Greater Cincinnati Health Council focused on health systems, hospitals, long-term care facilities, and select business partners, while HealthBridge supported health information exchange and provided technology solutions to care providers. The Health Collaborative was originally a multistakeholder convening organization, delivering cross-sector solutions and health improvement pilot projects to the region. Post-merger, the Health Collaborative brought all three organizations’ functions under one roof, along with a population health agenda, known as Gen-H.

Gen-H launched in 2014 under the leadership of the Health Collaborative and the United Way of Greater Cincinnati as a coordinated response to the region’s critical health disparities. Under Gen-H, regional stakeholders came together and committed to developing a regional health improvement plan using the collective impact model.

This collaboration created an opportunity to apply to be a bridge organization for Gen-H, with funding through the Center for Medicare and Medicaid Innovation (CMMI). Gen-H fosters partnerships among health systems, public health organizations, and social services to address health-related social needs. In 2017, Gen-H became a community hub for the AHC model and began working to address the health-related social needs of the region’s Medicare and Medicaid beneficiaries. Gen-H partners screen these beneficiaries using a validated survey tool and give them community resource referrals to help address challenges such as housing instability, food insecurity, utility needs, interpersonal violence, and transportation. Beneficiaries who are using emergency department services two or more times per year are also referred for community-based navigation services to further support their identified needs.

SHARED VISION

Guided by communitywide feedback and informed by health care data, Gen-H ultimately identified three core purposes:

- Addressing unmet health-related social needs
- Designing value-based care
- Empowering place-based health and wellness initiatives

Gen-H staff convenes community and health care partners to drive this work.

DATA MEASUREMENT

HealthBridge is the Health Collaborative's service line, supporting health information technology adoption, a health information exchange, and innovative uses of data for improving health care outcomes. HealthBridge is one of the nation's largest, most advanced, and most financially sustainable health information exchanges. It serves more than 30 hospitals, 7,500 physicians, and 800 practices, as well as local health departments, nursing homes, independent labs, radiology centers, and other health care entities across multiple communities in four states.

The HealthBridge mission is to positively impact health status, experience, outcomes, and affordability by fostering a connected system of health care and community health through innovation, integration, and informatics. HealthBridge and its community partners transmit more than 30 million clinical tests, images, and other results to authorized physicians each year through HealthBridge's secure electronic network.

Although still new, Gen-H is gathering data to show its impact, which in turn is used to enhance alignment across sectors. It has already used this data to conduct a gap analysis; the data will also be used to prioritize which health-related social needs to address as a community.

FINANCING MECHANISMS

Gen-H is primarily grant funded, with the largest amount of funding coming from CMMI. In addition, local foundations, the United Way of Greater Cincinnati, and the Robert Wood Johnson Foundation's County Health Rankings & Roadmaps program have provided program-specific funds.

The Health Collaborative is now discussing the possibility of establishing a wellness fund.

While the Gen-H work is new and the Year 2 evaluation is not yet complete, CMMI will be examining claims data for both a decrease in utilization and total cost of care for participating beneficiaries. If the data is supportive, the Health Collaborative may pursue a strategy to reinvest the savings.

GOVERNANCE STRUCTURE

The Health Collaborative is a backbone organization responsible for bringing all partners and stakeholders together. Based on its historic role as a neutral convener, it relies on a collaborative approach — bringing people together to tackle problems that they cannot solve on their own. Regular convenings include multisector partners who inform both the regional community health improvement plan and the AHC advisory council, which includes health care, community-based organizations, payers, elected officials, and business partners. The AHC advisory council's co-chairs and the Health Collaborative's executive director of population health strategies are the decision-makers for Gen-H. Decision-making for the region's health improvement plan is led by Gen-H's senior manager, in partnership with members of the implementation plan work group.

INSIGHTS FROM THE COLLABORATIVE

The Health Collaborative believes its strength as a backbone organization comes from its neutral standing, as well as its long-standing history of convening and its bringing together of multisector partners at the start of the Gen-H work.

“It is not a hospital, it is not a social service agency, it is not the government. We have a long-standing history of success with bringing people together and working toward a common goal,” says Kiana Trabue, executive director, population health strategies. “We are not playing favorites. We are not saying, ‘Hey, it’s the hospital’s responsibility,’ or ‘Hey, it’s the social service agency’s responsibility.’ We’re saying we all have a role to play, and we all need to have skin in the game in order to make this work.”

ALIGNING IN ACTION

The Health Collaborative's Gen-H initiative brings together 10 clinical organizations, two managed Medicaid plans, and three community-based organizations to address the unmet health-related social needs of Medicare and Medicaid beneficiaries across Hamilton, Butler, and Warren counties in Southwest Ohio. In addition to partner organizations, Gen-H brings together local elected officials, Ohio Department of Medicaid, United Way of Greater Cincinnati, and other community-based organizations to oversee Gen-H and to strategize around communitywide solutions to the region's most critical health-related social needs.

Gen-H has identified transportation as a top need. To address this need in a cross-sector way, the Health Collaborative's executive director of population health strategies joined the transportation committee for Hamilton County's Human Services Chamber (HSC). Based on HSC recommendations, the Southwest Ohio Regional Transit Authority Board adopted a resolution (<http://humanserviceschamber.org/wp-content/uploads/2019/10/SORTA-Board-Resolution-9-30-19.pdf>) to put a 0.8% countywide sales tax levy on the ballot next year to fund public transit and infrastructure projects.

If adopted, the levy is expected to pave the way for significant service improvements for Cincinnati Metro, including 24-hour service on key bus lines, increased frequency and weekend service, new routes to job centers, and improved crosstown routes. Notably, the resolution includes \$500,000 per year for two HSC-led advocacy efforts: a Transportation Empowerment Fund (<http://humanserviceschamber.org/wp-content/uploads/2018/04/Transportation-Empowerment-Fund-proposal.pdf>) and a commitment to expand Access service.

HSC's Transportation Empowerment Fund would provide free or discounted bus passes and other ride options to eligible low-income citizens through participating nonprofit and government organizations. The proposal is designed to help low-income riders overcome financial barriers associated with bus fares and future fare increases.

INSIGHTS FOR ALIGNING

- To move the work forward, the common purpose must be narrowed. Collaborators have many ideas about what to work on together, but getting the work off the starting block may require them to focus on a few highly impactful goals in a disciplined way.
- Collaborating agencies/members can continue to focus on their core missions and priorities, but they also must dedicate time and resources to maximizing impact and minimizing duplication in their participation in the Gen-H initiative and a coordinated regional implementation plan.
- Large health care providers are not expected to foot the bill or lead the charge. The collaborative members have resources and capacity at the community level that are enabled when United Way connects Gen-H with community leaders in local neighborhoods.
- The Health Collaborative uses the regional health information exchange's data infrastructure to inform the regional community health implementation plan. Having this public health data and engaging neighborhoods in developing their own community health dashboards further strengthens the collaborative's cross-sector approach.
- Developing a strong infrastructure that includes a backbone organization and access to regional and real-time data will help Gen-H build its value proposition and create paths to sustainability.

ALIGNING IN ACTION

HEALTHIERHERE



As the Accountable Community of Health (ACH) for King County, Washington, HealthierHere works across sectors to build an accessible and integrated delivery system that fosters health and wellness for all. By addressing social determinants of health (SDoH) and building strong partnerships between the health care, behavioral health, public health, and social service sectors, HealthierHere has begun implementing large-scale improvements in the delivery system, with the ultimate goals of reducing health disparities, improving health outcomes, improving client experience, and reducing per capita costs.



Lead organization: HealthierHere, the King County Accountable Community of Health

Lead sector: Neutral backbone organization

Location: King County, Washington

Year founded: 2017

Interviewee: Susan McLaughlin, executive director, HealthierHere

LOCAL CONTEXT

While officially established in 2017, HealthierHere’s roots date back to early local health and human services transformation efforts that predated Washington’s statewide efforts. In 2013, following passage of the Affordable Care Act, the King County Council passed a motion requiring the formation of a panel of community and clinical representatives to develop a regional plan for health and human services transformation. The 30-member, multisector panel produced a report, the King County Health and Human Services Integration Plan, to address population health and integration efforts in the region.

When Washington received its \$65 million State Innovation Model (SIM) grant, it used a portion to provide seed funding for nine regional ACHs. In King County, the Health and Human Services Transformation Panel transitioned to become the ACH’s informal governing body; this interim leadership council was managed within local government by Public Health–Seattle & King County. However, when the state received its Medicaid 1115 Waiver, it included stipulations that required ACHs to be stand-alone, nonprofit organizations. Thus, in March 2017, HealthierHere was spun out of county government and became a limited liability corporation under the Seattle Foundation’s fiscal sponsorship, and the transformation panel evolved into the 26-member multisector governing board of the King County ACH.

SHARED VISION

HealthierHere’s vision is that people in King County will experience significant health and well-being gains when the entire community works collectively to shift from costly, crisis-oriented responses to health and social problems to a connected system of whole-person care that focuses on prevention, embraces recovery, and eliminates disparities. To improve the system of care, HealthierHere and its partners have begun to strategically strengthen infrastructure and capacity, build partnerships, develop skills, share knowledge and information, collaborate on systemwide tools, and spark innovation — including incentive-based payment models — all while focusing on equity. This work aims to codesign, develop, test, and implement innovations in four target areas: integrating physical and behavioral health, providing safe and successful transitions (from

acute and specialty care, step-down, jail, and behavioral health), preventing and managing chronic conditions, and reducing opioid use.

HealthierHere uses some of its resources to support community members and community-based organizations to ensure that they can take a seat at the table. For example, HealthierHere provided resources for 18 community organizations to conduct surveys and focus groups; this effort captured the voices of more than 900 people in 33 different communities and 13 different languages to help inform HealthierHere investment strategies and transformation efforts.

DATA MEASUREMENT

The local public health department has significant data infrastructure and has negotiated data-sharing agreements with the state. HealthierHere contracts with the health department to support the ACH data needs. Also, because HealthierHere is a single-county ACH, its county partnership gives it access to broader data from the behavioral health and justice systems, the homeless information management system, and other data sources that it can match at the individual client level to assess impact. A major gap in data access that remains, however, is individual-level data related to social services.

In partnership with Public Health–Seattle & King County, HealthierHere established a performance data dashboard to examine waiver-specific metrics selected by the Health Care Authority and the Centers for Medicare & Medicaid Services. While these metrics are health-oriented, they enable examination by race and place, and HealthierHere hopes to broaden the metrics to include important regional and community factors. For example, the HealthierHere governing board recently approved a set of equity metrics that was codeveloped in partnership with representatives from each of the board’s four committees.

HealthierHere is also leading efforts to bring community information exchange (CIE) technology to the region. CIE is in the planning stages, but it is envisioned as a communitywide resource with ongoing funding through a public utility model and coordination (for the near term) by HealthierHere. The CIE effort serves as a concrete example of the waiver investment’s long-term value. It will be an ongoing resource that can identify access and capacity gaps at the individual client level that then can be pulled and matched to Medicaid data.

FINANCING MECHANISMS

The bulk of HealthierHere funding is through the state’s 1115 Medicaid Waiver. HealthierHere structures its budget to ensure that its resources address SDoH and health disparities. Of its project dollars distributed to provider organizations, 50% are allocated to the health care delivery system, 42% to community-based organizations that provide social services, and 8% to tribal partners. Within its administrative budget, almost \$500,000 is directed to community and consumer engagement and voice.

By the end of 2019, however, HealthierHere will have earned close to 80% of the available waiver dollars, with only a fraction more available through 2023. The organization — along with other ACHs in the state — is therefore pondering how it will continue transformation efforts and sustain the ACH infrastructure that has been built during the past few years once the waiver funds are exhausted.

“Will the ACHs exist post-waiver, or do we exist solely to administer the waiver and then we will go away? Every community is handling that conversation a little bit differently,” says Susan McLaughlin, executive director of HealthierHere. “We have learned a lot about the needs of our region. We think HealthierHere provides a value, and our governing board and partners are really talking about what kinds of gaps we could continue to fill.”

While it is not mandated in Washington, some of the ACHs — including HealthierHere — chose to set aside some of their waiver dollars for a wellness fund. HealthierHere’s board allocated 6% of its overall waiver dollars (about \$6 million) to seed its Equity and Wellness Fund. The vision is that this fund could be used to leverage other partners in this resource-rich region to contribute and grow the fund into a vehicle that would allow transformation efforts to continue under HealthierHere’s ongoing administration. However, these wellness fund efforts are currently paused while HealthierHere’s program implementation progresses and generates evidence to demonstrate the value of its transformation efforts. Nonetheless, the fund remains part of its larger strategic and sustainability planning discussions.

GOVERNANCE STRUCTURE

HealthierHere is governed by a 26-member cross-sector board with about one-third of its seats dedicated to community members, social service agencies, and tribal partners; one-third represented by the health care system, including hospital systems, community health centers, and community behavioral health agencies; and the final third representing government, payers, philanthropy, and other stakeholders. Certain sector seats are reserved for that sector's association or other local organization to nominate its representatives. Other seats are open and filled through an application process.

Board members represent their sector — not their organization. So, prior to casting votes, members have a responsibility to report to their sectors and get input as to how the sector wants to vote on decisions. This encourages broad engagement, as does the practice of open board meetings, which are attended by up to 30 people, depending on the topic.

All work goes through four formal working committees — community and consumer voice, finance, transformation, and performance measurement and data — which bring recommendations to the governing board. Committee representation mirrors the board's cross-sector representation, although not necessarily in terms of size.

INSIGHTS FROM THE COLLABORATIVE

McLaughlin credits HealthierHere's neutrality as a secret ingredient in its ability to work across sectors. "Because we are not tied to any single organization or sector, we can truly represent the consumer and needs of the region. It allows us to push innovations in a way that a single sector or organization may not be able."

Having the resources and time to do authentic community engagement and build trusted relationships is serving HealthierHere well. By slowing its resource deployment and program implementation, this ACH was able to listen and to learn — and thus to ensure that its efforts are truly community-driven.

“We’ve got to figure out how to set up payment structures that shift resources to the right places,” explains McLaughlin. “In these early phases, we are finding that most of the social service agencies are significantly under-resourced and do not have the infrastructure and the capacity they need to even begin the discussions, let alone develop new partnerships with the health care system. We have been really fortunate to use some of our waiver dollars to build the necessary infrastructure and capacity within the social service agencies to really participate in building the relationships with the health care delivery system that ultimately may be pushing or contracting with them to buy social services in the future.”

ALIGNING IN ACTION

Public Health–Seattle & King County has a long history of collaborating with the local housing authorities. In 2016, under the ACH umbrella, the King County Housing Authority, Seattle Housing Authority, and Public Health–Seattle & King County together received a grant from Data Across Sectors for Health. The grant enabled development of an integrated data system that linked Medicaid enrollment and claims data with public housing data. This gave the groups a better understanding of the health issues and health care utilization of public housing residents.

Better aligning housing and health data can inform policy, outreach, and programming interventions to improve the health of low-income residents, as well as allow organizations to more easily measure the impact of their efforts. In this case, the group’s longitudinal dataset (2012-2016) identified population overlaps between the Medicaid and public housing authority service systems:

- The number of public housing authority residents enrolled in Medicaid increased from 74% in 2012 to 83% in 2016, driven by Medicaid expansion.
- In 2016, public housing authority residents accounted for more than one in 10 of the total Medicaid enrollees in King County.

Given the magnitude of this overlap and the unique and ongoing relationships between public housing’s authorities and residents, there is significant potential for cross-sector efforts to improve population health and lower health care costs by targeting education, resources, and support to these residents.

“Housing and homelessness is a really complicated issue in King County, as well as other big cities, so from a HealthierHere perspective, we are looking at that data to help us think about the intersection of health and housing and identify innovations that we can test under the waiver,” says McLaughlin. “Prior to the waiver, the state provided some SIM grant funding for a pilot. In King County, we piloted the use of community health workers to work in public housing settings to provide health literacy, disease self-management support, and exercise and wellness programs. We are continuing to facilitate conversations at the intersection of health and housing and incubating ideas around where we might, as a system, do things differently.”

INSIGHTS FOR ALIGNING

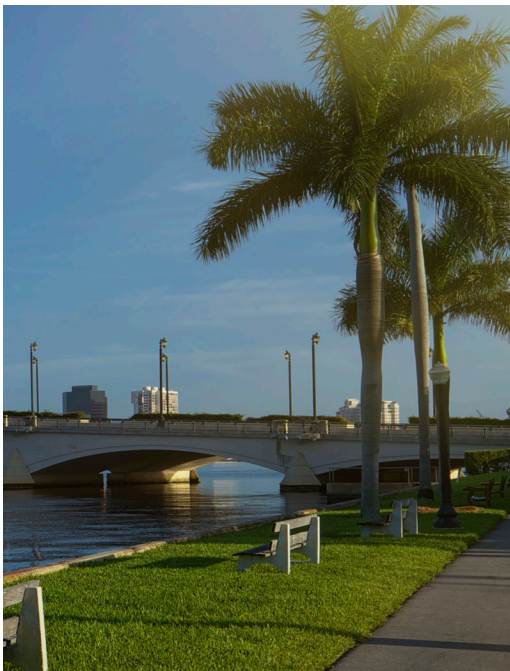
- The catalyst for HealthierHere was a SIM grant that provided seed funding.
- HealthierHere supports community codesign by giving community members and community-based organizations the resources they need to ensure that they can take their seats at the table.
- HealthierHere has stable financing through its Medicaid waiver but must plan for sustainability once the waiver ends.

ALIGNING IN ACTION

HEALTHIER TOGETHER



Healthier Together is a resident-led funding approach designed to solve local communities' most complex health issues, neighborhood by neighborhood. Initiating Healthier Together in 2013, Palm Health Foundation committed \$1 million each to six communities to make a lasting, sustainable impact around three priority areas: diabetes prevention and management, behavioral health, and family caregiving.



Lead organization: Healthier Together, Palm Health Foundation

Lead sector: Philanthropy

Location: Palm Beach County, Florida

Year founded: 2013

Interviewees: Patrick McNamara, Palm Health Foundation president and CEO, and Abigail Goodwin, vice president of grants and community investments, Palm Health Foundation

The six Healthier Together communities include:

- Healthier Delray Beach (2014);
- Healthier Jupiter (2014);
- Healthier Boynton Beach (2015);
- Healthier Neighbors (Riviera Beach and North West Palm Beach, 2016);
- Healthier Glades (2017); and
- Healthier Lake Worth (2017).

LOCAL CONTEXT

From its conception, Healthier Together was intended to depart from traditional responsive grant making by empowering residents to be at the center of systems change.

“Early on, the foundation really relied on trusted nonprofit partners — those that were previously funded or looked to in terms of thought leadership in the field — to invite others to the table,” recalls Abigail Goodwin, vice president of grants and community investments at Palm Health Foundation. “It was through existing relationships with the nonprofit community that we could extend an invitation to more formally engage the folks that they were serving and to create this effort that really honors community voice and then, over time, resources those folks to not only be part of the solution, but also to define the problem.”

Palm Health Foundation had a three-part vision:

1. Change long-term health outcomes in Palm Beach County and narrow health disparities among residents.
2. Increase capacity among individuals, organizations, and systems to impact lasting and sustainable change

3. Establish a new type of learning framework to evaluate the overall impact of the Healthier Together initiative.

The foundation used data to select the six communities, identifying concentrated areas throughout the county with low health indicators, gaps in services, and a high prevalence of risk factors among the social determinants of health (SDoH) impacting residents' ability to live healthy lives.

SHARED VISION

Because it was a new type of grant making, Palm Health Foundation admits that the vision required clarification, as its original theory of action was rooted in clinically based approaches to health. For example, the foundation originally looked for decreases in diabetes rates over a five-year period; improvement in awareness, access, and support for behavioral health; and increases in awareness of caregiver needs and access to resources. However, it quickly realized that the time frame and measures were not aligned with transformative community change efforts.

“Within the foundation, we had a real commitment and shared vision to invest in people,” says Goodwin. “Ultimately, people make up communities and people make up organizations, so if we are able to support people to do what they can, what they're good at, what they're drawn to, and to do more of it and deepen their skillset and knowledge, their toolbox, and not necessarily to professionalize everyone who comes to this work, we can equip people to navigate through their community challenges. This has been a cornerstone that we have really deepened over time.”

In some ways, the foundation views itself as a seventh community on this journey — one that has also committed to learning and evolving. The most noticeable shift is in the foundation's name change — from Palm Healthcare Foundation to Palm Health Foundation — reflecting the commitment and leverage behind addressing SDoH. Similarly, communities have also shifted to a broader definition of health.

“Any evolution in purpose has been community-directed,” says Patrick McNamara, Palm Health Foundation president and CEO. “We were very pointed early in this initiative. For instance, our objective was to see a reduction in diabetes rates in five years. We very quickly learned that is

unrealistic, especially if we're going to be true to the community-led process.”

McNamara points to the first Healthier Together community, in Jupiter, Florida, where the community drove the focus on healthy eating and active living as the solution — not just for diabetes prevention, but also for a healthier community overall. That upstream focus was more widely embraced among residents.

“The work really entails democratizing health and moving to change mindsets and unleashing new solutions in the social determinants of health,” says McNamara. “We see relationship development and change in mindsets as a really necessary complement to the technocratic problem-solving stuff that is absolutely necessary and will continue to go on. But problem-solving needs to be more adaptive and complemented by using these resident-led efforts in complex systems sort of work. It’s a feedback loop that is missing right now in the technocratic problem-solving process.”

DATA MEASUREMENT

The foundation also recognized early on that data collection would require a nontraditional approach that accounted for the endeavor’s complexity and emergent learnings. This approach now permeates the effort’s data collection and evaluation methods.

To present data and inform decision-making in ongoing community sense-making sessions, the foundation uses Results-Based Accountability. Yet, given that the community-based approach elevates the voices of those with lived experience, Palm Health Foundation felt that data collection and evaluation should also include lived experience. In seeking a solution that incorporated both traditional metrics and community voice, the foundation decided to deepen its own capacity. It has been working with Cognitive Edge and using SenseMaker software to collect stories that can be converted into quantifiable data that is heat-mapped to identify where public sentiment is moving.

“The theory is that as the world has become increasingly complex, and with our connectivity and accelerating pace of change — especially when we’re talking about social services and human systems — we are almost always starting in the complex adaptive arena,” explains McNamara. “Yet, often we treat these systems as if they’re ordered and simple, and we impose solutions that just don’t fit. To get used to operating in the complex, adaptive domain requires this regular collective sense making.”

FINANCING MECHANISMS

Palm Health Foundation originally committed to \$200,000 yearly for each community for five years, which includes the support for a full-time project director in each community. Beyond the five-year period, the foundation committed to support the project director role and to provide additional financial support through responsive grant making. The first two communities are now entering Year 6, which is a phase with less financial security.

“It has been a pretty powerful thing to watch as all the communities have been identifying their priority areas and constantly assessing where this work could live over time,” says Goodwin. “What would this look like if this rested with community? Where does that go? Who are the champions? So that’s something that is an ongoing process.”

Jupiter thought early on about how to get resources into resident hands, and it developed a minigrant program that has been adapted in the other communities. The foundation says these minigrants have served to build trust, community engagement, and local stewardship of shared resources. In Jupiter, individuals and small nonprofits can apply for \$2,500 grants that fund pilot projects that ultimately may pave the way for other funders to contribute. Selection of minigrant recipients involves community input, with more than 400 people participating. Today, all six of the local Healthier Together initiatives provide varying degrees of mentorship, grant-writing workshops, and supportive platforms for networking and collaboration.

“It has also been a big recognition on our part — that idea of financial sustainability was overwhelming and tended to dominate for so many. It is still a lingering issue, but we really wanted folks to consider this idea of sustainable impact versus the financial sustainability,” says McNamara. “We are bringing together our system partners and other funders and helping them to understand the value of this work — not that everybody has to work this way, but to help understand that there’s value in doing this sort of work, where it previously had been that really specific short-term return on investment and hitting targeted outcomes was the only way to work. We were the ones who were willing to push the boundaries and can take more risks so that they can now see value in doing that.”

A system partner recently made a \$15,000 match to the Healthier Together minigrant program, doubling the amount of money available to invest in resident ideas.

“The level of financial investment is a drop in the bucket for some of the work that’s being accomplished,” says Goodwin. “What we think a lot about is lasting impact, with policy change being the ultimate win and how that can be accomplished through community organizing. It looks different in each community, but it does not take a lot of money to be effective.”

GOVERNANCE STRUCTURES

The foundation invited participation among community partners and the people they serve. Following that, the initial steering committees were largely composed of nonprofit leaders, early community resident adopters, faith-based leaders, and members of active civic groups. Goodwin described the balance as 50% lived leaders and 50% learned experts from organizations. Palm Health Foundation played a backbone role, but the steering committee volunteers were the search committee for the project director and the ones identifying and vetting a fiscal agent.

“Engagement is a process, and we have really come to understand and build comfort around the idea that there is a place and time for folks’ involvement, and if they don’t stay on for the long term, it’s OK, and that the proverbial table is not literally a steering committee table,” says Goodwin. “Over time, it is cultivation of relationships out in the community, and that informs the work moving forward.”

In its backbone role, the foundation aided communities in “force field exercises” and collective sense making in order to hone community priorities. These exercises varied from highly structured and facilitated to those focused on making time for conversations.

“Through that process, people would continue to deepen their interest and commitment to this work,” says Goodwin. “It was a combination of art and science to really carefully assess where the energy was for pathways to form. There was this natural inclination to group by affinity and around these ideas to do further exploration. But over time — and as the first two communities are in year six now — we have really come to understand that these governance structures can slow the work and the degree of innovation and adaptability. We are in a period of transition right now, watching communities evolve from that early, early structured governance to a less formal network structure that’s more decentralized.”

The foundation launched roughly two communities per year, and McNamara says that the

learning from each launch provided valuable insights.

“While each community is very different and has different contexts, there were some common elements in the forming and establishing of each, including gaining comfort with the messiness involved with this,” McNamara says. “Striking a balance between the structure to set it up, but also going where the energy goes and paying attention to the feedback, helped the project directors to use adaptive leadership tools and skills for managing the effort.”

INSIGHTS FROM THE COLLABORATIVE

Palm Health Foundation recently completed a five-year assessment of its efforts to transform communities through Healthier Together (see https://healthiertogetherpbc.org/HT_Five-Year_Look-Back_paper_FLIP). Its key learnings focused on time, patience, and embracing adaptability.

“What was foundational for all of the communities was taking the time and really being patient to develop trusting relationships,” says McNamara. “There is a difference between folks coming in who are clinicians saying, ‘This is the definition of behavioral health, these are where the gaps are, and this is what we need to do,’ versus asking the community: ‘How do you guys define behavioral health? What is it that you see, and what do you think we can make progress on?’

“We got very different answers from folks once they saw that it was a level playing field and that their input and suggestions would really be taken to heart and taken into account,” McNamara says. “By creating a safe space for experimentation to fail, and letting folks put forward some novel ideas, and looking for emerging leaders in the community who had ideas, you can literally invest in residents and their ideas. When you partner with the community and you recognize strengths that are already there and leverage those, you get so much further than you would otherwise.”

ALIGNING IN ACTION

Delray Beach chose behavioral health as its area of focus, but community members said that they couldn’t get further without having some challenging discussion about race equity and behavioral health.

McNamara credits Delray Beach with leading the way for the foundation’s commitment

to sharing the Race Equity Institute workshops with people throughout all of the communities. Delray Beach hosted other community conversations as part of its novel approach to tackling behavioral health, including conversations in churches on mental health and getting the Delray Beach Police Department to adopt Mental Health First Aid training for all of its officers.

As an outgrowth of such efforts, individuals with lived experience with behavioral health; faith-based organizations, neighborhood groups, and other natural community supporters; service providers; system partners; and elected officials all provided input on how to create a countywide effort, later dubbed the BeWellPBC initiative.

Like Healthier Together, BeWellPBC supports resident-inspired solutions to address the county's behavioral health needs. With support from Palm Health Foundation — as well as other philanthropies, the county, behavioral health providers, and social service providers — BeWellPBC seeks to align systems, foster a community culture of health through community-identified innovations, and develop a behavioral health workforce pipeline.

ALIGNING DURING COVID-19

The foundation expanded its use of SenseMaker software to engage youth early in the COVID-19 pandemic to collect stories about how COVID-19 was affecting their lives. The learnings quickly identified the need to create a rapid-response team of volunteers to look at stories and reach out directly to people.

“We needed a mechanism to provide material assistance, because some of the stories were just so dire,” recounts McNamara. “It would have been unethical for us to hear them and not do anything, so we created the Neighbors Helping Neighbors Fund and offered a one-to-one match in the community up to \$200,000.”

The foundation looked to “nontraditional places of trust” in the community — churches and some community-based nonprofits — to give the money to in tranches, and then let them decide, based on the stories they were hearing in their community, who needed the assistance and who to give the money to.

McNamara credits the local project directors with “hyperlocal knowledge” for solving last-mile problems, such as food distribution.

INSIGHTS FOR ALIGNING

- Palm Health Foundation has operationalized the incorporation of community voice across multiple components:
- By listening to the community, it shifted its purpose from reducing diabetes to focusing on healthy eating and active living as a means to a healthier community.
- It used collective sense making around data to elevate the voices of those with lived experience.
- One grantee involves the community in its decisions related to awarding minigrants to ignite new projects.
- The projects' steering committee is a balance of 50% lived leaders and 50% learned experts from organizations.
- In line with the Framework for Aligning Sectors, the foundation saw how essential it was to change mindsets in order to achieve broader goals.
- The foundation also recognized the adaptive nature of working across complex systems.

ALIGNING IN ACTION

HEALTHY HOMES DES MOINES



Healthy Homes Des Moines started as a pilot program to provide home remediation and health education aimed at reducing the burden of childhood asthma. Although it includes a meaningful partnership among health care, public health, and housing organizations, the initiative is currently inactive and restructuring around sustainable funding. While it has not yet achieved the success that its partners believe is possible, this cross-sector initiative provides an instructive example of the importance of having the right people at the table — particularly those with a financial interest in the program’s success.



Lead organization: Healthy Homes Des Moines

Lead sector: Polk County Housing Trust Fund

Location: Des Moines, Iowa

Year founded: 2014

Interviewee: Eric Burmeister, executive director, Polk County Housing Trust Fund

LOCAL CONTEXT

Leaders from organizations across sectors had been in ongoing discussions about how to demonstrate the value of housing-related upstream interventions. When funding emerged for a pilot through the BUILD Health Challenge, the Polk County Health Department, the Mid-Iowa Health Foundation, and the Polk County Housing Trust Fund jumped at the opportunity.

The partners knew from existing community health data that instances of pediatric asthma were higher in lower-income neighborhoods where county housing records categorized many homes as being in poor condition. The partners also knew that environmental remediation of those homes could demonstrate the value of upstream interventions and improve the health of low-income residents.

The pilot specifically targeted pediatric asthma, for which an estimated four in 10 cases are attributable to home exposures (e.g., exposures to mold, mildew, indoor allergens, or pest infestations). The pilot would track patient progress over time following an in-home educational intervention and remediation; the goal was to demonstrate the value of an upstream intervention to the community and to health care providers.

The pilot was initially designed to require a referral from a medical professional to ensure an official asthma diagnosis. Referrals quickly became a struggle, however, as providers were slow to refer patients to the program.

SHARED VISION

Although there was broad, cross-sector interest in demonstrating the value of housing-related, upstream interventions, the central goal was always to improve children's health.

“All of us believe that we could demonstrate that in addition to improving the health of the kids, we could also save our health systems and our community money by attacking some of these things that were relatively inexpensive, instead of constantly seeing kids in the emergency room or urgent care clinics because they were having another asthma attack,” says Eric Burmeister, executive director of the Polk County Housing Trust Fund.

DATA MEASUREMENT

The value proposition was centered on the idea that data existed that would allow the organizations to track a child’s medical encounters before and after home remediation — and thereby track the impact on health care utilization, among other factors.

Healthy Homes Des Moines immediately set up a project-management tool, as the health care providers wanted the ability to follow the child’s progress through the intervention — from housing inspection to the remediation plan to education and so on. The dashboard was accessible to all participating organizations, including health care, housing, public health, and the visiting nurses organization that conducted in-home education.

Although the project-management tool enabled successful handoffs across the various process steps, it neither tracked population-level data nor interfaced with medical records. Data collection was further complicated by the fact that a patient’s post-intervention condition or subsequent hospital or clinic usage could not be tracked across the three area health systems without manually examining each patient’s medical records.

INITIAL IMPACT: 2015-2017

137 referrals and 42 families that completed the full assessment

- Increases in asthma-control scores
- A 50% decrease in the number of days that caregivers missed work and children missed school
- More symptom-free days
- Increased understanding of asthma management

FINANCING MECHANISMS

The BUILD Health Challenge provided the initial pilot funding, with matching funds from the three local health systems and foundations. The Polk County Health Department provided the home inspections, while the Polk County Housing Trust Fund paid for any necessary housing remediation.

The pilot was initially funded for four years, at which point the BUILD dollars had been spent and the health systems and third-party payers lacked sufficient interest in collectively funding the program costs and in-home education.

The founding partners decided to put the initiative “in a medically induced coma” as they explored options for sustainable financing. “The actual structure still exists. The idea still exists. The question is, how do we go on from here?” asks Burmeister.

GOVERNANCE STRUCTURE

Healthy Homes Des Moines was not incorporated; instead, it operated with two “tables.” Given that it began as a localized neighborhood program, the larger table consisted of community residents interested in public health, housing, and neighborhood redevelopment. This group met a few times a year and served as a means for communication and brainstorming.

The second table was a management committee consisting of a representative from every organization with a financial stake in the program — that is, the Polk County Health Department, the Polk County Housing Trust Fund, Mid-Iowa Health Foundation, the three hospitals, and the visiting nurses organization. This management committee provided the program’s “guard rails.”

INSIGHTS FROM THE COLLABORATIVE

The three local health systems had a seat at the planning table, showed initial buy-in, and provided early financial investment. Nonetheless, Burmeister says, there were probably only a couple of months when the program had sufficient referrals from the three systems.

“I think they thought it was a good idea, but when it came to figuring out how to integrate this into the culture of their clinics or their emergency room protocol for asthmatic kids, it just didn’t stand up,” says Burmeister. “There was nobody taking responsibility for getting the necessary paperwork done and getting families referred to the program. You really can’t blame people for having other concerns on their mind during an emergency situation.”

To compensate, Healthy Homes Des Moines expanded the referral source to include school nurses in the public school system. Referrals remained a challenge, however, as the program required a medical diagnosis of asthma.

“It became apparent to the management committee that the partner with the most financial interest in the program’s return on investment was missing from the table — the third-party payers, or specifically the managed care organizations for Iowa’s Medicaid program.”

While external forces can sometimes be a catalyst for aligning, in Iowa, Medicaid policy proved to be a barrier. “Unfortunately, at the time that we were embarking on engaging Medicaid folks, the state switched from a state-managed program to a third-party-managed program,” explains Burmeister. “In the summer of 2019, we had actually had arrangements with one of the managed care organizations to provide us a cohort of identified patients to work through the program, and they were going to reimburse at least the education part of it.”

But the managed care organization ended up pulling out of the state. Now, of the original three managed care organizations that Healthy Homes approached, only one remains. The organization is still trying to engage them and engage two new replacement managed care organizations.

Engaging directly with managed care organizations, Burmeister believes, will solve both the referral issue and the data issue, as Healthy Homes will have full access to all claims for each child, thus providing a better way to track post-intervention health care utilization.

The Polk County Housing Trust Fund, Mid-Iowa Health Foundation, the home education provider (Every Step), and the Polk County Health Department remain committed; however, the COVID-19 public health emergency has temporarily diverted the public health department’s attention.

“Had we had someone at the table who had something financially to gain, I think there would have been a different result,” says Burmeister. “While our guiding principle is about improving

kids' lives, we need to find somebody that says, 'It is in my best financial interest to make that happen.' Then we can start this thing up again in a minute."

INSIGHTS FOR ALIGNING

- As with other cross-sector alignment initiatives, this one came together around a one-time grant opportunity.
- The group's struggles with generating sufficient referrals highlight the importance of internal factors related to the capacity of organizations to achieve their goals.
- The work also highlights the importance of having a shared purpose beyond simply coming together to work on a grant.

ALIGNING IN ACTION

LIVE WELL SAN DIEGO



Live Well San Diego uses a collective impact model to achieve the countywide vision of building better health, living safely, and thriving.



Lead organization: Live Well San Diego

Lead sector: Government (San Diego County)

Location: San Diego, California

Year founded: 2010

Interviewees: Nick Macchione, director, San Diego County Health and Human Services Agency (HHS), and Carey Riccitelli, director, San Diego County HHS, Office of Strategy and Innovation

LOCAL CONTEXT

The county of San Diego Health and Human Services Agency (HHS) epitomizes aligning across sectors within the government domain. The HHS “super agency,” created in 1998, brought together health, public health, and social services; six years ago, it added housing, too.

San Diego County has more than 3.4 million residents and is geographically the size of Connecticut. It has six health service regions, including North County, which is the largest. Nick Macchione, now director of San Diego County HHS, credits his time from 1998 to 2008 as deputy director of San Diego’s North County service region with preparing him for his current role. Through the North County Collaborative, that region engaged more than 60 different partners around a vision of whole-person well-being before it was a popular notion, laying the groundwork for what would become Live Well San Diego.

“That was really almost a training camp for me,” says Macchione. “For 10 years, we formulated a common culture of treating the whole person, the whole family, and the whole community. We had lived experience with this in our policy, in our program, in our practice, which prepared me for when I was selected as the director for the entire agency. I could take our learnings from the North County and replicate it for the whole county.”

SHARED VISION

From 2008 to 2010, San Diego County HHS developed the framework for Live Well San Diego, which intentionally extends beyond traditional health care, public health, and social services to include safety and economic well-being. Live Well San Diego is a comprehensive vision for a region that is building better health, living safely, and thriving. Today, nearly 500 partners have formally signed on to enact this vision through a collective impact model, committing to support a common agenda, agreeing to track progress using common metrics, and coordinating efforts to positively affect quality of life.

“Live Well San Diego doesn’t belong to a single person, it is our way of life,” explains Macchione. “From how we have integrated our county budget of \$7 billion annually, to our partners, to how we operate, to even how we responded to COVID-19 — we do it all using the

Live Well San Diego framework.”

The organization’s partners include schools and education, business and media, cities and government, and community and faith-based organizations, with the latter accounting for nearly two-thirds of all partners. To realize its vision of building better health, living safely, and thriving, Live Well San Diego uses four strategic approaches: build a better service delivery system, support positive choices, pursue policy and environmental changes, and improve the culture within.

DATA MEASUREMENT

Live Well San Diego is data-driven. It uses data to measure collective impact, to drive decision-making in community enrichment plans (formerly called community health improvement plans), and to inform the public health accreditation process. San Diego County HHSA collects and shares data not only with committed partners but also with the entire community.

The Live Well San Diego vision includes 10 indicators that measure impact across five areas of influence: health (life expectancy and quality of life), knowledge (education), standard of living (unemployment and income), community (security, physical environment, built environment), and social (vulnerable populations and community involvement).

Live Well San Diego also provides training and tools for partners and residents alike to use its trove of data.

“Our signature data summit events happen each year and really evolved out of this deep conversation that we were having with our partners and our communities,” explains Carey Riccitelli, director of the San Diego County Office of Strategy and Innovation. “They understand that they have access to so much data that it can be overwhelming, yet we are asking them to help make decisions and to prioritize based on data. So, giving them a forum to be able to come together to not only learn what’s available but to really look at these indicators helps us move the needle.”

FINANCING MECHANISMS

Although Live Well San Diego was never a “grant-funded program,” aligning existing funding and leveraging grant opportunities has resulted in more than \$800 million in grant funding and

Medicaid waiver money. San Diego County HHSA now has a \$2.5 billion annual budget, up from \$1.2 billion when Macchione started as agency director in 2008.

“For us, it was never about treating funding like a grant, it was about making cultural change,” says Macchione. “We decided that if this framework is guiding the work that we do, then this is what we do. Initially, Live Well San Diego repurposed a couple of the agency’s staff working on health promotion, but we couldn’t departmentalize Live Well to a unit — it had to be the entire organization. Live Well is the entire county, our whole budget. You can’t cut out a movement when it is the whole essence of your organization.”

Macchione says he has seen other organizations that were too grant-centric and failed to elevate the vision beyond a subset of the organization. A line item can be cut, but strategically, an integrated vision is supported by the entire budget.

GOVERNANCE STRUCTURE

San Diego County HHSA is the backbone organization and provides Live Well San Diego with a support team to maintain the website, manage partner engagement, and host signature events.

Live Well San Diego community leadership teams are located in each of the six service delivery regions. They vary in size from 40 to 100 members and include representatives from schools, businesses, community-based organizations, hospitals, providers, and residents. Some community leadership teams established smaller steering committees and workgroups.

Each region is co-chaired by a county executive and the Live Well San Diego county-level leader, but the local playbook relies on priorities set by residents and local organizations using the Live Well San Diego framework. These priorities are captured in community enrichment plans that define local priorities based on data and community will. So, while priorities may differ region to region, the process is managed similarly.

“Our community partners brought to our attention that they didn’t want to call them community health improvement plans anymore because they now span health, safety, and thriving goals,” says Riccitelli. “We bring in training and data and presentations for them multiple times a year to help inform decision-making and set their priorities. This comes from the community.”

Since the early stages of Live Well San Diego, San Diego County HHSA and its partners

have hosted the multiweek Resident Leadership Academy training program. Sessions focus on topics such as community leadership, crime prevention and safety, land use, active transportation, and healthy food systems. Residents learn skills and best practices to address the issues that most affect their communities. Upon graduation, attendees have the knowledge, tools, and access to a support network to help them lead community improvement projects.

“The voice of the resident has been the secret sauce of what we’ve been able to do,” says Riccitelli. “Residents, community members, and neighborhood leaders come to our academies and learn about what it means to be an advocate for their community and how to effect change in a way that’s actually going to be sustainable.”

INSIGHTS FROM THE COLLABORATIVE

“You have higher degrees of trust because it’s not ‘I own it, and I’m inviting you,’” says Macchione. “Rather, it’s ‘We are building it together, and we need each other’s strengths to do that.’ And, let me be honest, visionary leadership is seeing what everyone is seeing and doing what no one else is doing — at the cost of mockery — in the present, for the betterment of the future.”

That vision has been, and remains, the driving force of Live Well San Diego, fortified by the human capital of the relationships that followed.

“We walked down Mockery Lane in the beginning of this in a big way,” Macchione recalls. “People were like, ‘Who appointed you?’ ‘This sounds like apple pie.’ And then there was the conspiracy that we were promoting the Obama agenda. But we saw the vision. And we stuck with it.”

Even in a region with a strong history of collaboration, building engagement and getting buy-in for the vision have been key.

“People started joining, and we made sure they knew they weren’t followers; they were leaders in their own right — leaders coming together for public good,” Macchione says. “We moved away from the fidelity of the profession — the health care profession, the public health profession, the social service profession, and the housing or public safety profession — to fidelity of the cause. When you align the fidelity to the cause and you have an inclusive vision, you get a higher degree of sincere engagement.”

A strong call to action also helped, leading to a bona fide social movement.

“We had a very tangible call to action: 3-4-50 — three behaviors cause four chronic diseases that lead to over 50% of all deaths worldwide,” says Riccitelli. “When we calculated those numbers in San Diego County, it was over 62% at the time — 62% of all deaths in this county were preventable because they were due to behaviors that could be changed and chronic diseases that could be prevented. This resonated not just with our typical partners, like clinics and hospitals, but it resonated with the business community and with schools and others and got them to the table.”

ALIGNING IN ACTION

Having solid footing for the Live Well San Diego movement enabled the region to respond quickly and in a coordinated fashion to the COVID-19 pandemic.

“The best antidote for a pandemic is population health, but it’s not time to plan for population health when you have a pandemic that shows up at your door,” says Macchione. “We were able to activate our entire Live Well movement in how we responded to COVID-19.”

On February 14, 2020, San Diego became one of the first jurisdictions in the country to declare a local emergency, and immediately convened the sectors to hear what the response needed to look like from their perspective.

“It became very clear to us that there were so many more sectors that needed to be included, but because we already had the framework, it was very easy to pivot and broaden our reach,” says Riccitelli. “We went from four to nine formal sectors and 12 subsectors. For example, education is a very broad sector, and the guidance and the recommendations that come out for childcare centers are vastly different from what are needed for universities. We were able to quickly begin to tailor our messages and the guidance and the recommendations by getting feedback from them about how it’s going and what their pain points are. It was about being able to have this two-way communication.”

Since the first week of March 2020, engagement with the sectors has remained high.

“We really have created this space for all of the county; whether it’s an organization or a hospital or a church or an individual resident, they feel like they know where to go to get

information,” says Riccitelli. “They know that things are changing all the time. They know that there’s a whole lot that we don’t know, but what we do know, we get out to them immediately. And it was because we had that framework already in place through Live Well San Diego that we could act on it immediately.”

INSIGHTS FOR ALIGNING

- Live Well San Diego is an exemplar in how it makes both data and measures available to community partners and residents alike, better preparing everyone to contribute to decision-making.
- Live Well San Diego is built to last by designating its entire budget in support of the vision.
- Live Well San Diego empowers community voices by providing the tools, training, and data needed to help residents become knowledgeable, engaged decision-makers in the governing process.
- The collaborative has built trust over time by cocreating the vision and the work side by side with community partners.

ALIGNING IN ACTION

MICHIGAN HEALTH IMPROVEMENT ALLIANCE



The Michigan Health Improvement Alliance (MiHIA) is a formal, multistakeholder 501(c)(3) nonprofit community collaboration working to achieve community health excellence for the 14-county region it serves in central Michigan. MiHIA fulfills its mission by focusing on the Quadruple Aim: population health, patient experience, cost of care, and provider well-being.



Lead organization: Michigan Health Improvement Alliance (MiHIA)

Lead sector: Health care

Location: 14-county region of Central Michigan

Year founded: 2007

Interviewee: Beth Roszatycki, CEO, MiHIA

LOCAL CONTEXT

Prompted by a federal and statewide grant application, MiHIA was formed in 2007 to act as a neutral convening organization for the region. That experience led to the realization that while Central Michigan's 14 counties were too small to be individually effective, they could collectively impact health by coming together as a region across sectors.

MiHIA remains an integrator organization and plays a unique role in outlining shared prevention goals, identifying evidence-based interventions, and coordinating funding streams in the pursuit of system-level improvements in population health, as well as health care quality and value.

More recently, after recognizing that transforming health regionally requires a vibrant economy, MiHIA and the Great Lakes Bay Regional Alliance joined forces to cocreate and co-lead the THRIVE initiative.

SHARED VISION

As the backbone organization for regional efforts, MiHIA establishes shared goals and objectives and sets collective targets with partners. Although the MiHIA board of directors determines the direction, it heavily relies on both its shared data platform and a regional community health needs assessment. The standardized needs assessment and performance measures are used throughout the region. In addition to data collection and analysis, the regional effort enables asset mapping, community input, prioritization of issues, an evidence-based action plan, and an ongoing measurement and evaluation process.

DATA MEASUREMENT

In its early years, MiHIA's funding — through a partnership on a federal Community Transformation Grant — established it as the regional entity supporting data collection, aggregation, and dissemination. This was the basis for what became MiHIA's online regional Health Dashboard 4.0 (<http://dashboard.mihia.org/>), a visual analysis tool that helps people in the MiHIA region monitor their communities' health and well-being; it also provides resources to improve their

health outcomes and offers a platform for sharing best practices.

Health Dashboard 4.0 provides high-quality, publicly available community health assessment data and health-indicator tracking for more than 300 measures. It is powered and supported by Conduent (formerly Healthy Communities Institute).

FINANCING MECHANISMS

MiHIA's operational costs are largely funded by three-year contributions from corporations and affiliate organizations. Expenses include daily functions such as core Quadruple Aim initiatives, IT support, communications, and marketing. Individual initiatives are typically funded through grants and foundation support.

Regional initiatives — particularly those that align with the THRIVE portfolio, the regional community health needs assessment, and the regional community health improvement plan — also require sustainable funding. To address this, MiHIA is working to design, build, test, and secure sustainability through a comprehensive funding and financing system, including a variety of unique methodologies and approaches to support its interventions portfolio. One component of this is the Regional Health & Well-Being Fund. This fund will blend multiple funding streams, including funding from area community foundations, public health department employee health plans, regional health plans, and hospital employee benefit programs and hospital community benefit dollars. The fund will support evidence-informed and practice-based community prevention activities for health improvement.

GOVERNANCE STRUCTURE

MiHIA has a formal structure, including a 23-person board of directors with three-year terms and steering teams for specific initiatives.

The board of directors serves as MiHIA's primary authority. It includes representatives of hospital systems, independent providers, universities, public health agencies, mental health organizations, consumers, health plans, and employers. This group oversees and manages the organization's affairs and business. Broad, multisector representation is most visible in the steering

teams, which attract participants based on topic-specific interests.

INSIGHTS FROM THE COLLABORATIVE

MiHIA attributes its success to building good will, gaining trust, articulating the value proposition, and establishing a unifying process for all stakeholders. Open, bidirectional communication has been key to building transparency and helping people see both the larger picture and how they can contribute to the collective effort.

“It is all about buy-in — that they are a part of this, that they are helping shape this, and that this is theirs just as much as it is the person’s sitting next to them in the room,” says Beth Roszatycki, MiHIA’s CEO. “The other part of getting buy-in is really laying out the business case and the value proposition for them to be involved. And that’s going to be different for every sector. It boils down to conversations to learn about their strategies and goals — coming to their table and building relationships.”

ALIGNING IN ACTION

Recognizing the inseparable link between economic success and health, MiHIA and the Great Lakes Bay Regional Alliance agreed in 2016 to co-lead the THRIVE initiative to transform the region’s health by building a vibrant economy. THRIVE is based on the idea that a region’s health is much greater when the regional economy is strong; this, in turn, is possible only with a healthy population.

THRIVE’s work is founded on several principles, including a commitment to regional impact, multisector participation, investment in upstream efforts that target health drivers, and economic success.

THRIVE is currently working to implement Phase 1 of its portfolio of interventions. These initial eight interventions are attracting new industries and business markets to relocate to the region; providing comprehensive mental health screening, referral, and placement; developing a regional health educational hub; enhancing technology to achieve coordinated health care services; advancing patient safety; improving prenatal, infant, and maternal health; reducing risky behaviors

from adverse childhood experiences and enhancing trauma-informed care; and developing a regional opioid strategy.

INSIGHTS FOR ALIGNING

- MiHIA has been deliberate in building infrastructure to support the collaborative's core mechanisms.
- The organization recognizes the importance of data in building partner commitment, bringing focus to programming, and securing funder commitment. It has invested effort and resources into building a data platform that is a tool for both the collaborative and the public.
- The tiered governance approach facilitates strategic input and direction from leaders across sectors, as well as opportunities for local actors to participate in steering committees of interest that drive key programming across the region.

ALIGNING IN ACTION

NCCARE360



NCCARE360 is North Carolina's first statewide coordinated care network to electronically connect people with identified needs to related community resources. The network also includes a feedback loop that reports on the outcome of each connection.



Lead organizations: North Carolina Department of Health and Human Services and the Foundation for Health Leadership and Innovation (FHLI)

Lead sector: Health, social services, and philanthropy

Location: North Carolina

Year founded: 2019

Interviewee: Chris Scarboro, senior program manager, NCCARE360/FHLI

LOCAL CONTEXT

NCCARE360 is grounded in the assumption that if people’s social needs are effectively managed, their health outcomes will improve. The state of North Carolina, including the governor’s office and North Carolina Department of Health and Human Services (DHHS), promoted the idea of investing in health, not just health care, as the desired way to invest in a healthier state.

In 2018, a public-private partnership between DHHS and the Foundation for Health Leadership and Innovation (FHLI) released a request for proposals. It included a few prerequisites, including that applying organizations use existing structures and already be doing this type of work in North Carolina. United Way of North Carolina was an ideal partner; as the state association for 52 local United Ways, it administers the statewide NC 211 information and referral system. Other selected implementation partners include Expound Decision Systems, which created a data repository model, and Unite Us, which provides the care-coordination technology platform to send, receive, and track electronic referrals.

SHARED VISION

NCCARE360’s core assumption is that social needs impact health outcomes. This assumption serves as the unifying vision among its partners, who are collectively addressing the social determinants of health for North Carolinians. Grounded in a No Wrong Door approach, NCCARE360 receives referrals electronically from health care providers or self-referrals through the website or phone-based care navigators; it then connects the referrals to community-based organizations to address food, housing, transportation, and other needs.

DATA MEASUREMENT

Data sharing is central to NCCARE360. A public community resource directory serves as a repository for thousands of community referral organizations. Then, guided by a data governance structure, the organizations are formally onboarded into the electronic platform to ensure seamless referrals and outcome tracking. NCCARE360 uses the Unite Us platform and integrates with clinical platforms such as Epic.

Data sharing occurs at both the micro level, to electronically track individual referrals, and the macro level, for planning and programming purposes. Micro-level case data is shared with the referrer and the community organization receiving the referral. At the macro level, NCCARE360 collects and shares with onboarded partners data related to network performance (number of organizations, referrals, clients, etc.); network efficiency (time to connect to an organization, case closure, etc.); community impact (resolved services, client outcome, community resource gaps, etc.); and network impact (needs addressed, accuracy of referrals, percentage of cases closed with positive outcomes, etc.).

“The data is incredibly important because it allows us to quantify the social network and social need to a degree that I don’t think we’ve ever had before,” says Chris Scarboro, senior program manager at NCCARE360/FHLI. “Being a state effort, it provides the ability to look and see the regions being impacted and the demographic that is being impacted. Do we have areas of need where we don’t have organizations to fill that need? From a policy perspective, that’s incredibly valuable.”

Both levels of data feed into an ongoing evaluation process. Individual organization and regional progress reviews are underway as part of a rapid-cycle evaluation. A longer-term, system-level evaluation will test the fundamental assumption that there is health utility to the NCCARE360 system.

FINANCING MECHANISMS

NCCARE360 is primarily grant-funded through 2021, but it has begun entering into care-coordination contracts that will also start paying for operations. NCCARE360 is contracting with larger health systems and payers that potentially could see tangible, clinical, and financial benefits by using the system, and NCCARE360 will continue to target this group as part of its sustainability efforts.

GOVERNANCE STRUCTURE

The NCCARE360 system’s development, implementation, and management, including overall governance and decision-making, occurs through the public-private partnership between DHHS

and FHLI.

“We try to be as democratic as we can,” says Scarboro. “We talk through big decisions with everyone because it affects everyone, but contractually these two organizations are responsible for the management of the program.”

This governance oversees the partnership-building and onboarding of thousands of county-level community organizations, a process that began in spring 2019. The onboarding process starts with a strategy session to identify the key local players, understand regional needs, and build partnerships with those doing the work. The entire process, including onboarding and training, takes about 90 days.

INSIGHTS FROM THE COLLABORATIVE

Scarboro says partner engagement has been strong.

“I have been pleasantly surprised that everyone is engaged around the assumption that if you manage social need effectively, that people will have better quality of life and better outcomes.

That is not something that we need to convince people of,” Scarboro says. “However, there are different motivating factors in terms of why they’re working with the network. That is something just to be aware of, and it takes some time to work through.”

Building trust at the local level and building community engagement are also large parts of NCCARE360’s strategy. Recognizing that building trust takes time and that each county’s implementation window is only about 90 days, NCCARE360 relies on partnering with trusted, established organizations in the community.

“We are working with churches and barbershops and many other organizations where people congregate, and they trust the people that they are talking to in those organizations,” says Scarboro. “In many cases, there’s a stigma attached to some of these nonmedical needs. And so we’re thinking outside of the clinical box and working with others where there is already a trusted relationship, in addition to health departments and primary care physicians, on these things.”

ALIGNING IN ACTION DURING COVID-19

Using CARES Act money, North Carolina began implementing a community health worker

(CHW) initiative that had been in the works for years. A total of 250 CHWs are being hired and trained to assist 50 high-caseload counties with COVID-19 contact tracing, as well as assisting individuals to meet their broader health and social needs. The CHWs are working with local health departments and will also leverage NCCARE360 to address health and nonmedical needs by connecting individuals with resources for health care, food, housing, employment, and other financial assistance.

The COVID-19 pandemic made NCCARE360 restrategize; as with its expansion of CHW support, however, the pandemic has enabled the statewide network to accelerate many of its efforts.

“We pivoted to a virtual process and fast-tracked bringing counties on,” explains Scarboro. “We were actually able to bring all 100 North Carolina counties onboard quicker than planned, nearly six months ahead of schedule. COVID-19 put an incredible need on the social network in the state, like everywhere throughout the country. We have seen food insecurity triple in our data. Housing needs have definitely increased just as utility assistance has increased. Our data and network allow us the ability to look at all of this and really see the regions where that’s being impacted.”

INSIGHTS FOR ALIGNING

- NCCARE360 demonstrates the need for a close association between data and appropriate governance.
- Like many efforts that are aligning sectors to better serve individuals and communities, NCCARE360 started with grant funds but is transitioning to a payer-funded model so that the initiative is built to last.
- NCCARE360 focuses on trust and community voice as important factors in reducing stigma associated with some social needs.

ALIGNING IN ACTION

NORTHWEST OHIO PATHWAYS HUB



The Northwest Ohio Pathways HUB is a certified Pathways Community HUB, a model that the Agency for Healthcare Research and Quality recognizes as a data-driven approach to identify and address risk factors at the individual and community levels. The Pathways Hub is an example of health care and the social sector aligning around an important public health issue: infant mortality.



Lead organization: Northwest Ohio Pathways HUB (housed within the Hospital Council of Northwest Ohio)

Lead sector: Health care

Location: Toledo, Ohio

Year founded: 2005

Interviewee: Carly Salamone, assistant director, Northwest Ohio Pathways HUB

LOCAL CONTEXT

The Northwest Ohio Pathways HUB is a data-driven care-coordination and support system that connects low-income residents to needed medical care and social services to improve their overall health outcomes and quality of life. The Pathways HUB system relies on community health workers (CHWs) — who are based in clinics, social service agencies, family centers, churches, and other community organizations — to help people get needed care and services by removing common access barriers.

CHWs canvas the community for at-risk residents or take referrals; they then assess enrolled residents and develop a comprehensive, outcome-driven plan that prioritizes their health and social needs. The HUB system has 20 pathways for unmet needs, including health care, food, housing, and transportation. Organizations employing CHWs receive payments from Medicaid managed care plans once clients are successfully connected to services and meet the outcome milestones.

The Pathways HUB has 15 full-time employees and 40 CHWs employed by 15 care-coordination agencies. The HUB launched in 2005 to address infant mortality, which assistant director Carly Salamone called a “huge problem.” Since its launch, the HUB has expanded; it now serves the northwest Ohio region (Henry, Huron, and Erie counties) and addresses diabetes, heart disease, and other chronic conditions. However, about 60% of the HUB’s current clients are pregnant — with another 30% of childbearing age — and infant mortality remains the biggest priority.

SHARED VISION

The pay-for-performance model establishes shared goals and outcomes for all community care-coordination agencies that employ CHWs. Compensation is based on meeting specific, measurable outcomes — such as clients attending prenatal care appointments, having stable housing, and delivering a healthy baby — that are achieved by completing HUB pathways. Medicaid managed care organizations and other funders pay set fees for successfully completing these pathways; in 2018, the top completed pathways included client education, social service referrals, and medical referrals.

DATA MEASUREMENT

In 2018, the Northwest Ohio Pathways HUB had 40 CHWs at 15 care-coordination agencies serving 1,615 northwest Ohio residents. Data is critical not only for reimbursing the HUB, but also for quality improvement, planning, and expanding partnerships.

Data comes from multiple sources: standardized data that CHWs enter about their clients, the local health department's vital statistics information, and the Hospital Council of Northern Ohio, which conducts communitywide health assessments. The HUB combines data into a deidentified dashboard to track productivity as well as unmet community needs. Further, the advisory committee members bring in data from their own agencies to create a complete picture of the community. Payers receive reports that track client risk factors and health and social outcomes based on the completed HUB pathways they pay for.

FINANCING MECHANISMS

The Northwest Ohio Pathways HUB uses a mixture of grants to sustain special projects and HUB infrastructure. In addition, five Medicaid managed care plans are contracted to pay the HUB for CHW outcomes. The HUB is a pay-for-performance model and pays care-coordination agencies for services provided by the CHWs and the outcomes they achieve with their clients. In order for this to occur, the HUB bills Medicaid managed care monthly for all services completed in the previous month for its individual members.

GOVERNANCE STRUCTURE

The Pathways HUB is housed within the Hospital Council of Northwest Ohio, a hospital association for the 18-county region. The HUB was established to fix the region's high rates of low-birth-weight babies. The hospital council was selected as the host organization because of its neutral standing with all of the health partners, as well as the success of its CareNet Toledo/Lucas County,

a charity care network for low-income residents who are uninsured but ineligible for public or private coverage.

Although the HUB was initially focused on health care — that is, on placing CHWs in the health systems, in the health department, and in the Federally Qualified Health Center — over the past five years it has begun building nontraditional partnerships with other entities (e.g., housing and transportation agencies, community centers, and churches) as a way to bring people previously unconnected to care into the health care system.

“When you have CHWs who are working in the health system, you’re really getting more residents who already crossed paths with the health system,” says Salamone. “The real question is how do we get people integrated into the health system who have never been there before or who have had bad experiences?”

The advisory committee is composed of medical professionals and representatives from Medicaid managed care plans, the Toledo Fire & Rescue Department, the city of Toledo, the Department of Neighborhood and Business Development, local health departments, the homelessness board, the judicial system, police, local foundations, the March of Dimes, and other organizations. Volunteers from the HUB’s advisory board also review applications from organizations that want to become a care-coordination agency that houses CHWs.

INSIGHTS FROM THE COLLABORATIVE

Salamone says one of the biggest keys to successful local alignment is relationships.

“You need to have good, established, long-standing relationships with your community partners to be able to go in and propose something like giving 25 housing choice vouchers to our families. That’s not something that you can just walk in and demand of the city’s housing authority.”

Salamone says another key ingredient is commitment — the commitment of leadership and a commitment to collaborating.

“I think it comes down to leadership from each sector being on the same page — leaders who know that it is about the bigger mission, as opposed to the bottom dollar. It still takes years to

build [alignment], regardless of how passionate everyone is about it.”

ALIGNING IN ACTION

All Northwest Ohio Pathways HUB partners are invested in decreasing infant mortality and understand that addressing it benefits the community. Partners align their work so that all systems in the community are “moving in the same direction” and working together to break down barriers to success.

The HUB found that nearly half of its pregnant clients had no transportation. Because data shows that a lack of transportation is a risk factor for infant mortality, the HUB partnered with the Ohio Department of Transportation to apply for funding through the Federal Transportation Administration. This funding and a partnership with a local transportation company enabled the launch of the Baby and Me Ride Free program, which lets pregnant women and mothers with a child under age 1 receive an annual bus pass for the transit system.

Another pregnancy risk factor is unstable housing. After working with the local housing authority over a long period, the HUB was able to bring the issue of infant mortality to the forefront. Infant mortality is now a priority in the housing authority’s strategic plan, which reserves 25 housing choice vouchers for pregnant women and women with children under age 1. Pregnant HUB clients are given priority for low-income housing.

INSIGHTS FOR ALIGNING

- The Northwest Ohio Pathways HUB builds on an urgent need to address the high rates of low-birth-weight babies.
- The HUB model offers a great example of aligning with payers, which produces a sustainable funding stream for much-needed services.
- By employing CHWs with lived experience, the model emphasizes the use of strong community engagement to address people’s goals and needs.

ALIGNING IN ACTION

PARKLAND CENTER FOR CLINICAL INNOVATION



Parkland Center for Clinical Innovation (PCCI) is a nonprofit health care data science, analytics, and innovation organization. PCCI built one of the first connected communities of care (CCCs) in the nation and rooted it in its proprietary information exchange platform. This history gave PCCI — as a backbone organization — the experience it needed in aligning diverse stakeholders to then serve as a bridge organization for the Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities (AHC) Model in Dallas.



Lead organization: Parkland Center for Clinical Innovation (PCCI)

Lead sector: Data Science and Analytics Organization

Location: Dallas, Texas

Year founded: 2012

Interviewee: Keith Kosel, Ph.D., former executive adviser to the Dallas Accountable Health Communities team and co-author of *Building Connected Communities of Care: The Playbook for Streamlining Effective Coordination Between Medical and Community-Based Organizations*

LOCAL CONTEXT

PCCI started as a department within Parkland Health & Hospital System and was spun out as an independent, nonprofit organization in 2012 to support both Parkland's needs and additional transformative initiatives under the PCCI name. PCCI remains tightly connected to Parkland, the Parkland Foundation, and the Parkland Community Health Plan, with collaborative work focusing on the needs of vulnerable populations across North Texas and beyond.

The Dallas-area CCC was initially a partnership between Parkland and two large anchor organizations — the North Texas Food Bank and the Metro Dallas Homeless Alliance — with many smaller community-based organizations (CBOs) under their umbrella. Over the past year, and particularly during the COVID-19 pandemic, PCCI has developed a much stronger relationship with Dallas County Health and Human Services, which did not participate in initial efforts.

SHARED VISION

CCCs are designed to support the safety and well-being of vulnerable and underserved community residents by aligning clinical and social service providers. They inherently recognize the need to seamlessly provide services that are complementary to medical care, including housing, food services, and employment assistance. Those coming together to form a CCC partnership fundamentally share a desire to seamlessly connect, communicate, and coordinate among health care, social services, and other entities, potentially including the public health, criminal justice, and education sectors.

DATA MEASUREMENT

Data sharing is central to the CCC framework. PCCI uses the Pieces™ Connect platform, which was developed by its for-profit sister company, Pieces Inc. This two-way communication messaging platform enables back-and-forth communication, as well as tracking of referrals made from health care providers to CBOs; it also enables electronic case management around the social determinants of health (SDoH). In the face of the COVID-19 pandemic, this system has been expanded to help

with hot-spotting, contact tracing, and other public health needs.

The Pieces Connect system is used to measure and evaluate what is working and what is not working across multiple levels — program, CBO, and community resident. Data is shared with all participants in the CCC AHC network.

“It started out that data was always blinded; you are health care provider or CBO A, B, or C. But we have moved to sharing data in an unblinded format when the data and the underlying need warrant it,” explains Keith Kosel, former executive adviser to the PCCI AHC team.

This goes for sharing data that conveys both good news and bad news.

“You have got to take even a small accomplishment back to the health care provider or CBO to celebrate it: ‘That’s great, the nutrition counseling is working,’” says Kosel, adding that when things are not going well, you must address that as well. “People showed up at the food pantry, but they were turned away. What went wrong?”

Having people involved in CCC management and oversight who have the time and capability to analyze and interpret the data is essential, as is communicating findings from the data to community members.

“This is where you need experienced staff that can look at the data and say, ‘Wow, the majority of people that are coming into this food bank are diabetic, but most of the food we have is not ideal for them,’” explains Kosel.

FINANCING MEASUREMENTS

PCCI was fortunate to have generous seed funding from a Dallas-based philanthropic organization that allowed it not only to build the technology platform, but also to bring together partners and all of the small CBOs, and to fund the work for several years prior to receiving the CMS AHC award.

Even CCC-related projects sometimes succumb to the “one and done” problem, where once a grant is over and the funding is gone, so is the collaboration. Kosel says PCCI has thus learned that it is critical to have anchor organizations mentally and financially invested in a CCC effort, as they may be called on to contribute additional funding to keep the network afloat until it is self-sustaining. But, Kosel advises, to get that additional funding, it is imperative to demonstrate

early on to the funders that the effort is working.

“You have got to be able to demonstrate pretty quickly — with data — that you are beginning to move the needle,” says Kosel. “Does it have to move a lot? No. But it’s got to be moving in the correct direction.”

To help drive home this point, Kosel explains a program PCCI was involved in where diabetes and hypertension patients were connected to food pantries capable of helping them manage their dietary and nutrition needs.

“The program saw an 8% decrease in emergency department visits,” Kosel says. “Well 8% isn’t a lot, but the control group showed a 48% increase in emergency visits. So, the alternative of doing nothing was worse. Most people turn up their nose at 8%, but if you multiply that by the number of individuals you’re talking about times, say \$1,500 per emergency department visit, all of a sudden now you’ve got a lot of savings. That’s a quantifiable result and a start at demonstrating a positive impact of the initiative. The data has to say something beyond how many people you’re feeding.”

To make a program sustainable past the initial grant term, a health system or hospital at risk for caring for the population could theoretically pay a small amount, say \$5 per person, to the food pantry for providing nutrition counseling and helping patients select nutritious foods to help better manage their diabetes.

“We’re not talking a lot of money here,” says Kosel. “For every 20 people who receive the food bank’s help, if four or five of them change how they look at something as simple as selecting brown rice over white rice, and in so doing reduce the likelihood they will end up in the emergency department, it becomes a cost savings to the health care provider. Here again is where having the data to document these changes is invaluable.”

Kosel says that participants in large demonstration programs, like the ones CMS supports, need to think of sustainability from the beginning.

“CMS demonstrations act as a fire-starter or an accelerator,” says Kosel. “Once you take the accelerant away, you need to keep the fire going, and we know that doesn’t always happen; in the real world, sometimes the fire goes out.”

Kosel advises that initial conversations with CBO partners should be direct about the

importance of collecting the data, looking at the data, and making sure that the effort is moving in the right direction.

“Most of the money CMS earmarks for its demonstration programs is aimed at supporting learning and identifying more effective and efficient ways to generate health, and that’s a good thing,” says Kosel. “My worry would be that when the money stops, if those organizations have not capitalized on that money to really change their practices and generate demonstrable results, they may revert back to the old way of doing things. Sustaining change, until it becomes the norm, is not easy. Those that have changed their workflows and their processes, and have some evidence that the changes bring about better health and well-being for their community’s residents, will be in a stronger competitive position going forward.”

GOVERNANCE STRUCTURE

Experience has taught the PCCI leadership that governance is a multitiered process. When building a CCC, particularly in the first year, governance is more easily achieved with a smaller group of partners — one or two large anchor institutions and three or four smaller, but critical, partners. These partners, with a backbone organization’s support, can begin to build a game plan — that is, a strategy for what they want to do, how they are going to do it, and the future network’s “rules of the road.”

Key foundational questions and considerations include these: What’s a memorandum of understanding going to look like for participants? What kind of data is going to be collected? What kind of data is going to be shared? How is this CCC network going to be funded? Keeping the group small reduces the amount of disagreement and makes decision-making faster.

In the second governance stage, several new partners are brought in to serve more tactical or operational roles, and they may have less input on strategic decisions. This stage also includes planning for the next network tier of community-level participant organizations — in the case of the Dallas network, this included individual food pantries, homeless shelters, and faith-based organizations.

Kosel indicates that, in parallel with early governance discussions, PCCI always conducts a readiness assessment. This helps both the governance group and PCCI, as the backbone

organization, understand the community and its needs. Such assessments should include clinical and social factors; these may already be documented in a hospital or health system's community health needs assessment or a community needs survey conducted by the United Way, the Salvation Army, or another large social service entity. The readiness assessment should also look at technology capabilities and the experience of the network participants.

In the second year of development, when seed money is likely diminishing, a more permanent, sustainable governance structure should be in place, possibly with a few other partners for both financial and operational support. The focus in Year 2 is on longer-term planning, including succession planning in the face of leadership change or withdrawal of a main organizational player.

“When beginning to work with the CBOs to implement the network's technology, you must clearly lay out the workloads and expectations about what has to be done and in what way,” says Kosel. “It is important to take the position that there are certain things the CBO will have to do if it is going to be part of this network. If you leave it up to the individual CBOs, the results will be all over the board and the CCC network will suffer. PCCI learned this lesson the hard way, and it took a concerted effort to realign participants' thinking.”

INSIGHTS FROM THE COLLABORATIVE

While not completely unexpected, Kosel says there is an inherent difference between what a cross-sector partnership envisions and how CBOs work day to day. Ultimately, much of how things actually work depends on building trusting working relationships among network participants, the governance group, and the backbone organization.

“We made mistakes, as I'm guessing most everybody else does when they're trying to build connectivity between health care, public health, and CBO entities,” admits Kosel. “If people don't see or understand the value of the network, then they're not likely to share information back and forth. Our tip-off that we had some problems was when people weren't completing the loop. Somebody at a health care provider would make a referral to a food pantry and they would never hear back from the food pantry. That's as bad as the old model where a patient is handed a piece of paper with the address of a food pantry and told to go there for food. The whole idea of this information platform is to see the entire process playing out — ‘Sally Smith with diabetes is

coming over [to the food pantry]; Sally got to the food pantry, and here is what we did for Sally.’ This allows the clinician and the food pantry to be on the same page.”

Acknowledging that relationships and communication are the bedrock of the network and the workflow, Kosel notes that revisiting the value proposition of aligning is critical as the network evolves.

“While keeping an eye on the operations — is it working the way you envisioned? — backbone organizations must be communicating continually with network participants. Are you visiting with and building relationships with the CBOs?” asks Kosel. “Ask the participants, ‘How is the CCC working for you? What problems are you encountering?’ This relationship building and maintenance is really, really labor intensive. That’s probably why most people don’t do it given the scale of the community networks that they’re putting up.”

This also argues for starting a CCC small and growing it in measured steps.

Kosel recalls that in Dallas, at the end of the CCC’s first year, there were many CBOs participating, and it was difficult to find time to reach out to all of them and build solid relationships. Most came in under the umbrella of the two anchor organizations. Ultimately, however, many of these small CBOs needed guidance and direction and an understanding of why the network came together, how it operates, and the role of each CBO in the network.

“It doesn’t take long for the wheels to come off the wagon in that sort of scenario,” says Kosel. “Especially for front-line staff, you have to give them the full story. Give them a thorough understanding of what the CCC network is trying to accomplish and what their role is. If they are expected to screen 50 extra people a day for SDoH needs, they need to know that up front.”

ALIGNING IN ACTION — DATA ACROSS SECTORS OF HEALTH

As an early test of the CCC concept, PCCI participated in the Data Across Sectors of Health (DASH) program. The premise was that Parkland providers — the physicians and the case managers — knew that patients with hypertension and diabetes often had food needs. These patients were either getting the wrong kind of food, or they didn’t have access to food, much less nutritious food. In

such cases, it may have been noted in a medical record that the patient should be on low-starch, low-sugar diet, but that's where it ended.

CCC's electronic Pieces Connect platform enabled clinicians to send that dietary message to the food pantries where these patients were getting their food, creating a case management partnership between the clinicians and the CBOs.

This closed-loop model used existing relationships, technology, and staff to address patients' food needs. Three large food pantries were selected for participation because they:

- Were members of the North Texas Food Bank network,
- Had rotating nutritionists that would visit the food pantries, and
- Served large numbers of Parkland patients.

“Most food pantries will not mandate that clients only select healthy food,” says Kosel. “That said, we wanted these three food pantries to provide nutrition counseling and then strongly recommend what food they should be selecting and why they should be selecting it.”

In interviews, patients reported that the food pantries encouraged them to try healthy items. Upon questioning the patients, PCCI determined that it was the relationship between the food pantry staff and the patient — the personal touch and guidance — that ultimately changed food selection behavior on the part of many patients.

“It goes to show that case management that's done in a trusting, honest, and open way, with some degree of structure to it, can be effective for a large portion of the population,” Kosel says. Data showed that, in addition to a small decline in emergency department visits by patients who received nutritional counseling at the food pantries, there were improvements in medication compliance and a reduction in clinic visits missed over the course of the program.

“One of the most interesting takeaways was how positively patients reacted to questions we asked them about understanding their illness and their responsibility for their care. We asked questions like, ‘Do you understand your disease better now than you did before the program? Do you now have a better sense of what you're responsible for with regard to managing your health

versus before the program?” says Kosel. “Responses came back in the neighborhood of 80% to 90% positives. Patients see these CBO staff that are providing the nutrition counseling and food every week. They talk to them, they trust them, they look like them, and many of the counselors have taken the same path that the patient is on. It makes sense that this may be the way to build patient engagement at the grassroots level.”

While funding for the nutrition counseling stopped when the grant ended, the referral system remains in place and Parkland clinicians continue to use it.

ALIGNING DURING COVID-19

In relation to the pandemic, PCCI’s primary aligning activities included advancing identification of COVID-19 hot spots and facilitating contact tracing using PCCI’s COVID-19 Dallas Dashboard (<https://covid-analytics-pccinnovation.hub.arcgis.com>).

PCCI has a strong data science group and is well-known for building predictive models. Traditionally, its models include things like predicting 90-day pediatric asthma exacerbations that will lead to a hospitalization or identifying patients at high risk for having an adverse drug event. With the COVID-19 pandemic, Parkland was interested in having PCCI help to build predictive models around hospital capacity. Similarly, Dallas County Health and Human Services wanted PCCI to help it to identify hot spots within the county and at ZIP code — and, if possible, neighborhood — levels.

“The question became how do we go beyond just telling people what the current rates are, to how do we begin to give them more information about the incidence and the prevalence of the virus in their particular neighborhood?” Kosel says. “PCCI’s models can identify cases down to the street address level to identify which neighborhoods within ZIP codes are a real hot spot for COVID-19 cases. We can identify those individuals in the community that are positive for COVID-19 and their geographic proximity to patients coming to Parkland for a clinic visit or hospitalization. This proximity information was developed into a proximity index to help Parkland know which incoming patients should be targeted for COVID-19 testing.”

Kosel adds that CBOs, which know some of the patients and communities really well, can target boots-on-the-ground efforts using medical or nursing students and community health workers to do contract tracing. These contact tracers work with local CBOs — food pantries and homeless shelters — to enhance the effectiveness of contact tracing efforts.

“We could have something on the 6 o’clock news, but a lot of the folks that we’re targeting are not news watchers. They get their information from somebody else that is in the homeless shelter or in the food pantry line,” Kosel explains. “We have started to build that communication network through faith-based organizations with the food pantries and the homeless shelters. We think by optimizing the CCC network we have a really quick and effective way of getting information about what’s happening with COVID-19 in the community into the hands of the people that can potentially use it.”

PCCI continues to study the efficacy of the CCC in times of crisis.

INSIGHTS FOR ALIGNING

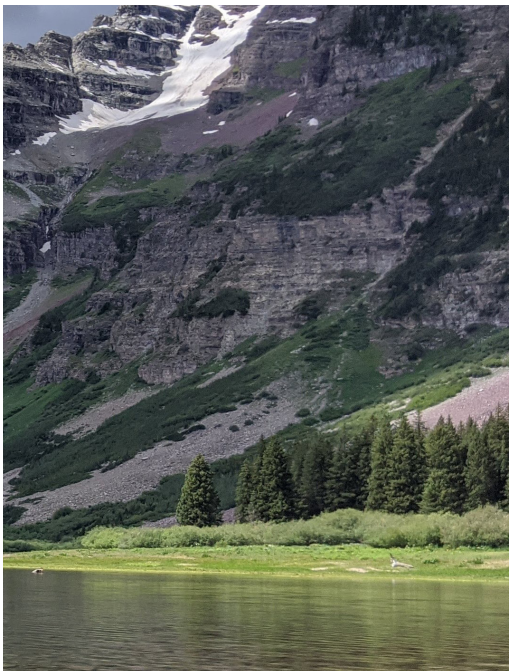
- The CCC demonstrates that one way to align systems that are built to last is to involve anchor organizations that buy into the concept both mentally and financially
- A multitiered structure, especially early on, may help to build the collaborative through a focused engagement of the different partners.

ALIGNING IN ACTION

ROCKY MOUNTAIN HEALTH PLANS



Rocky Mountain Health Plans (RMHP) provides a unique example of a payer facilitating regional efforts to address social determinants of health (SDoH). RMHP is a bridge organization within the Accountable Health Communities Model (AHCM), coordinating efforts in a largely rural area.



Lead organization: Rocky Mountain Health Plans

Lead sector: Health care payer

Location: Western Colorado

Year founded: 2017, as the bridge organization for the Accountable Health Community

Interviewee: Kathryn Jantz, Accountable Health Communities Model director

LOCAL CONTEXT

RMHP is one of seven regional accountable entities (RAE) for the Health First Colorado Accountable Care Collaborative (Colorado’s Medicaid program). RMHP connects Health First Colorado members with both primary care and behavioral health services for the large Western Colorado region, which includes Larimer and 21 other counties. Each RAE serves as a primary care case management program that provides additional services to support whole-person care, including activities to address SDoH.

RMHP’s participation in AHCM closely aligns with the RAE’s goals and expectations. All of Western Colorado’s Region 1 RAE counties, except for Larimer, are included in the AHCM. The AHCM grant expects partnerships with food, housing, and transportation sectors, as well as other community-based organizations, to engage nonmedical partners.

Fortunately, the needed infrastructure was in place with community leadership and community partners to support RMHP’s vision to create an accountable community with coordination between provider organizations and human services in this large geographic region.

SHARED VISION

Many of RMHP’s community partners were independently interested in the Centers for Medicare and Medicaid Services (CMS) AHCM. However, CMS designed the program with volume in mind: 75,000 screenings per year to start. Given the region’s rural and frontier nature, however, no single community had the volume needed to meet this requirement; the region’s largest city, Grand Junction, has only around 63,000 people.

RMHP was committed to pursuing a strategy around SDoH and felt a responsibility to support the community infrastructures that serve its membership; therefore, RMHP applied to be a bridge organization for the AHCM.

“Once awarded, we really had to focus our attention on the specific tactical outcomes we were expected to achieve,” says Kathryn Jantz, RMHP’s director of AHCM. “If we had a blank slate, we may have spent two years refining a collaborative community vision. Instead, we were immediately held to CMS’ high standards of social needs screening, care coordination, and community convening.”

Jantz reports that the AHCM work includes balancing CMS requirements, priorities of communities, and incorporating RMHP’s strategy and long-term vision.

DATA MEASUREMENT

Because screening occurs at a member level, participating clinical sites can view the results of a screening that preceded engagement with them, regardless of where it occurred, and including its changes over time.

RMHP gives clinical sites weekly feedback about screening volume and people opting into care coordination. RMHP’s partner is Quality Health Network, the local health information exchange; it gives clinical sites and subregions monthly visual data on both the prevalence of social needs and member-level screenings. Analytics examine screening results by income, race/ethnicity, age, gender, and county, and also look at larger utilization trends (e.g., emergency department use and social needs). These comprehensive reports go to each of the partners, who then share the data with their communities.

Because screening is built into Quality Health Network, the infrastructure can be maintained post-grant.

FINANCING MECHANISMS

As a health plan, RMHP is considering ways to incorporate social needs screening into broader integration efforts. Data from social needs screening can be used to inform payment adjustment, population stratification, and population-based interventions based on community need.

“We are committed to continuing a social needs screening vision and have been really cautious to build a program that is sustainable,” explains Jantz.

Providers are not paid on a per-screening basis (although some low-dollar incentive payments are made to the clinic and directly to its staff), and all care coordination is built into RMHP’s existing documentation infrastructure. Additionally, all community alignment and community convening rely on pre-existing relationships with organizations.

“We hope we have positioned each of the community partners to be more successful in their continued funding by arming them with data about the needs of their population, fostering

skill-building and strengthening their relationships in the community, and giving them an influx of money for five years,” Jantz says. “We are hopeful that we will pretty seamlessly move into a sustainable long-term strategy that includes social needs screening and robust community partnerships.”

GOVERNANCE STRUCTURE

RMHP has a funded contract with each organization leading the AHCM in its community. In three communities, these organizations are local ones that facilitate health alliances and/or provide care coordination. In two communities, the lead organization was initially the local public health organization, but they ultimately were less comfortable encouraging and supporting screening in clinical sites.

Every two weeks, two people from each lead organization and RMHP meet as a group with an external facilitator. Large quarterly meetings are also held with all of the partners (approximately 180 people). Each lead organization is responsible for engaging its community partners and managing community-level meetings.

Many places already had an existing community convening infrastructure or governance structure that they adapted for this program. Most decisions are made by consensus; however, because this effort follows the CMS project structure, some decisions are predefined by the program model.

ALIGNING IN ACTION

In some Western Colorado communities, the percentage of eligible people actually enrolled in the Supplemental Nutrition Assistance Program is as low as 13%.

“What we are trying to accomplish is not that, in one month, we increased mass enrollment by X%. Although that would be fantastic, what we’re trying to do is actually destigmatize and change the culture around accessing social resources. This culture change must come first.”

While individual members’ issues are being addressed, Jantz says a lot of the cultural change is occurring on the provider side. Previously, providers were more concerned about liability, offending members, and not having an immediate solution if a need was identified.

“Having worked with these clinics for years now, they are telling me stories of ‘aha moments’ by CEOs in small towns who personally knew members but were completely unaware of their financial or social challenges,” says Jantz. “It is really about increased awareness. Hopefully, it will change their practice, the way that they approach their patients, the way they engage in their community, and the way that they spend their community benefit dollars. In small communities, clinical site leaders wield clout in their community beyond their official professional role.”

ALIGNING DURING COVID-19

Many of the communities in the RMHP region are ski resort communities that are facing unemployment rates of 30%. Continuing social needs screening has thus become tricky, especially given that these vastly expanded needs coincide with clinical sites being overwhelmed by COVID-19 and facing their own capacity challenges.

“We have tried to partner with clinics to really think about how they deliver clinical care and how can we support them,” Jantz says. RMHP took concrete steps, such as creating functionality to allow screenings via telehealth. But, more broadly, RMHP is trying to engage in bigger conversations about how clinical sites can prioritize thinking about whole-person health during a significant recession and a public health emergency.

INSIGHTS FOR ALIGNING

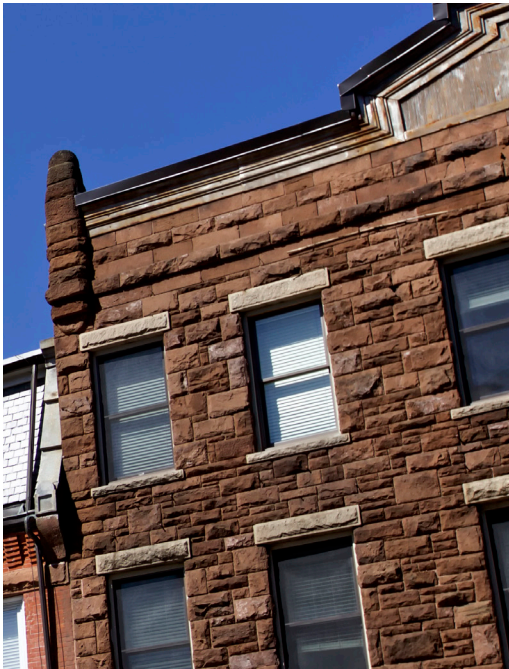
- RMHP’s work in AHCM is another example of cross-sector alignment activities that are driven by both a federal grant and a policy opportunity.
- RMHP has found a way to share governance across 180 partners and a vast geographic region.
- A key for financial sustainability may be in demonstrating the value of connecting patients to social services and resources.

ALIGNING IN ACTION

VITA HEALTH & WELLNESS DISTRICT



A decades-long relationship between Stamford's public housing authority (Charter Oak Communities) and the local health system (Stamford Health) enabled a land swap that ultimately revitalized the city's West Side neighborhood through a collective impact approach. The thriving, health-themed neighborhood they created offers visual proof that addressing the social determinants of health (SDoH) can close health disparities and improve personal well-being.



Lead organization: Vita Health & Wellness District

Lead sector: Public housing authority

Location: Stamford, Connecticut

Year founded: 2010

Interviewee: Vincent Tufo, CEO, Charter Oak Communities

LOCAL CONTEXT

Ten years ago, both Charter Oak Communities and Stamford Health were at a critical juncture; after years of underinvestment and a changing marketplace, they had each independently committed to revamping their organizations. Their leaders at the time had already begun collaborating and were forward-thinking enough to see that strategically aligning their individual organization's plans for development around a joint mission could create greater collective impact.

Charter Oak Communities sought to completely redevelop the obsolete Depression- and postwar-era public housing into new, mixed-income communities. For assistance, it turned to federal Housing and Urban Development (HUD) grant programs such as HOPE VI, along with similar assistance from the state of Connecticut. Stamford Health simultaneously committed to remaining in the West Side neighborhood and reinvesting in it by building a new state-of-the-art medical center.

To move from high-rise to townhome-style housing, Charter Oak needed additional lower-density land. Similarly, Stamford Health needed space to accommodate new development so that construction could proceed while its existing hospital remained operational. The two organizations thus created a money-free land swap: Stamford Health gained an old public housing site next to the hospital, while Charter Oak gained hospital-owned land elsewhere in the neighborhood that it could redevelop.

“We basically said, ‘It’s all about land. You need this acreage, and we need that acreage. Let’s just total it all up and agree that we’re simply going to swap the deeds on these properties,’” said Vincent Tufo, CEO of Charter Oak Communities. “Once we did that and we really committed ourselves, that was really the beginning of the Vita Health & Wellness Partnership. But it took all of 10 years to be at the point where we could consummate the deal.”

SHARED VISION

As Charter Oak Communities and Stamford Health were committing to independently reposition their businesses, the Affordable Care Act was passed and provided additional incentive to work

collaboratively to create broader community uplift around a shared vision.

In 2011-2012, Stamford Health and the Stamford Health Department jointly conducted the first community health needs assessment. That assessment identified the community immediately surrounding the hospital as being among the city's neediest, with the least healthy residents. It also served as a call to action, galvanizing multisector partners to begin meeting regularly.

A HUD grant under the Sustainable Communities Program provided resources to conduct an extensive community-based strategic-planning process, a number of neighborhood studies, and stakeholder engagements that resulted in a strategic vision that has guided the work ever since. Indeed, the Vita Strategic Vision became a comprehensive, place-based approach that addresses not only the availability of quality affordable housing and safe recreational space, but also access to medical care, nutritious food, and educational services.

“Having a clear set of goals or standards that the community holds in common is in and of itself a value,” explains Tufo. “Our language, our connections, have certain assumptions built into them, and not incidentally, our funding community is insisting upon more effective cross-sector collaboration.”

DATA MEASUREMENT

Data is available on a program-by-program basis. Vita Partnership is committed to long-term quantitative and qualitative assessment. In addition to the Stamford Health community health needs assessments, Vita creates annual reports for each program, which are shared through presentations and multiple learning exchanges.

Mixed-method evaluations have become a general practice, using data from a variety of sources to broadly examine not only what really happened, but also why it happened, how it happened, and how things can be done better.

“We think that this approach is key to doing any measurement of the social determinants of health,” says Tufo, “because what you're not necessarily doing is expecting that a particular intervention — let's say food security — is going to have a measurable effect over a reasonable period of time as to whether or not children become more effective learners.”

FINANCING MECHANISMS

Charter Oak Communities acts as the fiduciary organization, providing oversight and administration for the Vita Partnership’s contractual arrangements, grants, and staff.

Charter Oak Communities and Stamford Health fund a backbone operating budget of several hundred thousand dollars that covers general administration, project direction, fundraising, and communications services. All program funding comes from grants.

“We don’t currently have a solution for alternate sources of funding for the backbone function,” explains Tufo. “Fortunately, right now both organizations are able to maintain the current level of funding for backbone activities. We’d like to expand this role, but short of getting a municipal funding source or another large institutional partner, right now we’re pretty much status quo.”

GOVERNANCE STRUCTURE

The Vita Partnership has developed a larger footprint — expanding from the West Side to a larger, citywide initiative — and recently updated its memorandum of understanding with participating organizations. This MoU delineated three tiers of participation: the steering committee, the program tier, and the community tier.

Having intentionally decided not to incorporate as a legal entity, the Vita Partnership instead uses a three-tiered structure. The steering committee oversees the strategic direction and approves projects and the way the collaborative fulfills its responsibilities. The committee consists of two representatives from Charter Oak, two from Stamford Health, key staff members, and a rotating community representative.

The *program tier* consists of approximately 25 regular, active member organizations. These organizations participate in critical Vita activities, including a monthly learning exchange program, collaboration on individual programs, and outreach and fundraising on a program-by-program basis. The organizations are invested in collective impact and are fully committed to addressing SDoH and capable of building bridges across different sectors.

The program tier organizations reflect the cross-sector approach and include executive directors of organizations representing human services, behavioral health and substance use, physical health, early childhood education, public education, employment, housing, municipal government, youth development, and public health.

“Increasingly, what keeps and further knits us together is that we are involved in a number of programs where multiple organizations routinely work together collaboratively on specific programs,” says Tufo. “We also tried to encourage organizations to consider other types of arrangements, some of which are structured partnerships with program commitments, but there are also unstructured relationships where we see organizations naturally gravitating toward each other.”

Finally, the *community tier* consists of heavier representation from community-based organizations. Although these organizations provide direct community assistance, their representatives participate with less regularity than those from other tiers.

INSIGHTS FROM THE COLLABORATIVE

Taking the time to build trust and build relationships is central to the Vita Partnership’s success. Stamford Health and Charter Oak Communities spent 10 years building relationships before they could consummate the land swap, and it has taken another 10 years of aligned partnership, shared vision, and coinvestment to enable the transformation of Stamford’s West Side.

“There was an underlying lack of trust between the hospital and the community. There was a sense that the hospital had abandoned the community and the community was somehow a threat to their livelihood,” explains Tufo. “There were barbed wire fences and guard towers in the hospital parking lot looking over the neighborhood, which sent a message to this community that ‘We are in your neighborhood, but we are not part of your neighborhood.’”

The first step here was to break down the distrust and the cynicism; the next was to move from a transactional connection to a strategic connection. Partner organizations are following a similar path. Family Centers, a Vita Health & Wellness partner, is the largest human services agency in Stamford and Greenwich, and it has been around for 120 years. When the agency did its internal strategic planning, it adopted the Vita core values as its strategic vision.

“The Vita Bible is now becoming their operating playbook,” says Tufo. “It is working externally at the Community Table as well as internally within many of the organizations, as they are embedding the Vita vision into their core principals. That takes time, but you can imagine over the course of five, 10 years, they might embed the Vita concept into practice.”

ALIGNING IN ACTION DURING COVID-19

“The question is, do you have the foundation to adapt those relationships to effectively support each other through this crisis?” says Tufo. “Additionally, we know many institutions are more insular. How do you take advantage of this time, the mutual need, to break down some of those insulators? What is it that you have that is of value to the other party? Is it information? Is it relationships with the community?”

The Vita Personal Protective Equipment (PPE) Initiative provides PPE to all of Stamford’s front-line workers in nonprofits and civic agencies during the pandemic. The Vita Partnership received a private donation that enabled them to import directly from a reliable, midlevel supplier in China. That initial funding enabled purchase of a baseline inventory that will be resold at cost to any of the agencies that qualify. Those funds will then be used to replenish supplies as long as needed.

“This need came out of the Vita Community Table,” says Tufo. “We heard from many of our partners that, even though they are doing all of the essential work in terms of maintaining their community connections, providing food support at food pantries, they weren’t able to acquire PPE. This program allows us to help protect the workers and the clients of our partners during this time and helps keep people out of the hospitals by preventing the spread of the virus.”

INSIGHTS FOR ALIGNING

- The two parties were brought together by a shared sense of urgency: each needed the other's land.
- New policy opportunities — in the form of the Affordable Care Act — gave the parties further incentive to work together.
- Vita Health & Wellness Partnership deliberately chose a governance model that did not create a corporate entity, showing that successful collaborations can be governed in multiple ways.
- The Vita Partnership highlights the importance of having strong relationships through cross-sector alignment, which lets the organization take quick, multisector action and manage through crises, such as COVID-19.

ALIGNING IN ACTION

WESTERN IDAHO COMMUNITY HEALTH COLLABORATIVE



To get the biggest impact out of their investments and community health initiatives in Western Idaho, payers, foundations, health systems, and public health came together in early 2019 to form a 10-county collaborative and align each other's strategies and investments. The resulting Western Idaho Community Health Collaborative (WICHC) represents just under half of the state's population.



Lead organization: Western Idaho Community Health Collaborative

Lead sector: Public health

Location: 10 counties in Western Idaho

Year founded: 2019

Interviewee: Alexis Pickering, health strategist, Western Idaho Community Health Collaborative

LOCAL CONTEXT

In Idaho’s decentralized structure, each health district represents multiple counties. Central District Health represents the most populated district and is viewed as the most cutting-edge in the state with respect to policy, systems, and environmental change initiatives. It also had a track record of working with insurers, foundations, and health systems on work site wellness, health transformation, and community health improvement initiatives. In addition, Southwest District Health, which represents rural and frontier communities, had also begun to transform the way it worked with its communities to improve health.

“Our partners knew the work that Central and Southwest District Health were able to do and how they can be a great convener and, together, create a backbone organization that can bring all these different players together and overcome conflicting agendas,” explains Alexis Pickering, WICHHC health strategist.

Aligning these two public health districts was instrumental in accelerating interest in Southwestern Idaho’s Treasure Valley, which is the state’s most populated region. Together, the two health districts approached the legislature for an unprecedented funding request aimed at transforming how community health was approached in the two districts.

SHARED VISION

ALICE (short for Asset Limited, Income Constrained, Employed) is a new United Way measurement that defines and attempts to understand the struggles of the “working poor” — that is, “households that earn above the Federal Poverty Level, but not enough to afford a bare-bones household budget.” ALICE measures such things as the cost of transportation, food, health care, and housing

The ALICE Report analyzes what it really costs to live in certain counties and drills down to the ZIP code or sometimes even census-tract level across Idaho. The ALICE measurement is of particular importance in Idaho, which has one of the nation’s highest percentages of individuals with minimum wage jobs. In recognition of Idaho’s high poverty rate and struggling middle class, WICHHC is focused on initiatives that target the population “most at risk of falling off the cliff,” says

Pickering. WICHC used the Results-Based Accountability process to home in on this population’s shared indicators — health care, transportation, food insecurity, housing, wages, and trauma — to guide the collaborative’s work.

DATA MEASUREMENT

“Everybody knows that WICHC needs to have a shared data component, and this is probably the hardest thing,” says Pickering.

Traditionally, health systems and public health departments have conducted their own needs assessments, but recently United Way and a local health system partnered on a community health needs assessment, which was viewed as a step in the right direction.

WICHC has convened a data work group with the support of a graduate student. While working toward the macro data-sharing goal, the partners shared data needed to complete the Results-Based Accountability process.

Pickering says that deciding whether they needed the shared data infrastructure first or should just start working while they built it was a classic chicken-and-egg conundrum. They ultimately whittled down the possible indicators to those that reflect the ALICE population’s needs, address social determinants of health (SDoH), and are available at the county level for at least five years.

“The problem is, in Idaho, and I’m sure with a lot of places, we just have so many issues,” says Pickering. “We are data rich, but information poor. And there is hardly any qualitative data out there.”

On the macro front, WICHC is involved in several ongoing conversations, including with the state health data exchange.

FINANCING MECHANISMS

In spring 2019, with private funders in hand, WICHC pursued and received matching legislative funding to help build its infrastructure. In 2020, it received its second round of legislative funding, with reinvestment from all of the original private funders and one new funder.

Pickering says that the big plan is to create a wellness fund based on initial and additional investments from private funders and shared savings dollars as part of Idaho’s health care transformation efforts resulting from its \$39.6 million State Healthcare Innovation Plan (SHIP) grant. To apply for this funding, communities must demonstrate that their initiative would both target the ALICE population and address an upstream need.

GOVERNANCE STRUCTURES

WICHC is a 21-member collaborative that represents subject matter expertise across community health sectors, including dental, behavioral health, nursing, physicians, public health, hospitals, transportation, local government, and community-based organizations. The leaders of the funding organization also have a separate funding council.

The collaborative’s executive committee consists of the collaborative’s professional staff, a physician, a United Way representative, and the director of the public transit authority. Given the collaborative’s early stage, governance is evolving and may involve rearranging the funding council to incorporate more of the executive committee, while still being mindful of funders driving the agenda.

INSIGHTS FROM THE COLLABORATIVE

“To be successful in Idaho, we need to connect with the conservative part of the health transformation conversation, and that includes reducing costs,” says Pickering. “So, it is blending improving health outcomes and an intrinsic drive to cut costs.”

Pickering says that WICHC’s creation was due in part to external pressure to do things differently at a broader, health-system-transformation level, as well as to funders’ desire to see the most impact for their investments.

With a track record of innovation and past success as a neutral convener, the local public health departments had the credentials to lead these regional efforts to find cross-sector solutions.

ALIGNING IN ACTION

Before WICHC was created, smaller collaborations had emerged using the local public health district as the backbone organization to align and leverage resources. Elmore County, for example, has high childhood poverty rates, many mental health issues, and high rates of domestic violence and violent behavior. Despite having an Air Force base there, it also has low educational attainment and a lack of physical infrastructure for healthy living — that is, no Complete Streets, limited playgrounds, and disconnected sidewalks.

Galvanized by poor results from a countywide health assessment, Pickering and Elmore County formed a multisector coalition to work together to solve these complex issues. They assembled a diverse group of stakeholders centered around improving the results, specifically targeting the built environment and increasing physical activity, connecting resources, and preventing tobacco use.

Together, the local coalition and Pickering — at that time, a policy analyst with Central District Health — identified specific strategies to develop infrastructure to support physical activity, including building a playground, improving safe routes to school, and hosting walkability workshops. As a result of this collaboration, the county coalition received a grant and coordinated matching dollars from the community to build an all-ages playground that is open to the public after school hours. One city in the county is also adopting a tobacco-free policy in the parks and has nearly completed a new downtown revitalization plan with improved sidewalks and network connectivity.

Counties and collaborations such as the one in Elmore County will be able to utilize WICHC as a larger framework to connect with regional stakeholders, access other resources, and receive investments to solve their challenges. WICHC will also provide technical assistance to aid coalitions in tapping into federal and state funding, as well as matching funds to advance goals that address SDoH and align with WICHC's strategies.

“WICHC is developing a playbook of strategies, allowing communities to provide input on the tactics and strategies they will pursue. This allows WICHC to meet communities where they are and empower the communities to make these strategies and their impact their own. It is

more of this ‘comprehensive community’ approach,” says Pickering. “We have this 21-member collaborative that represents all these different sectors. We will help connect them to these different groups, and then show how communities can also align their resources that are within their own community to also address the same goal.”

ALIGNING DURING COVID-19

Building on the trust established over a few years between the Elmore County coalition and the WICHC, the collaborative asked coalition members how they were doing with COVID-19 and if the collaborative could assist with any gaps.

Broadband was an existing issue that is of urgent importance for people trying to access health care services. To address this, WICHC used its connections to a state senator, who in turn worked with the governor’s task force and the Department of Commerce to leverage federal and state funding to improve the broadband.

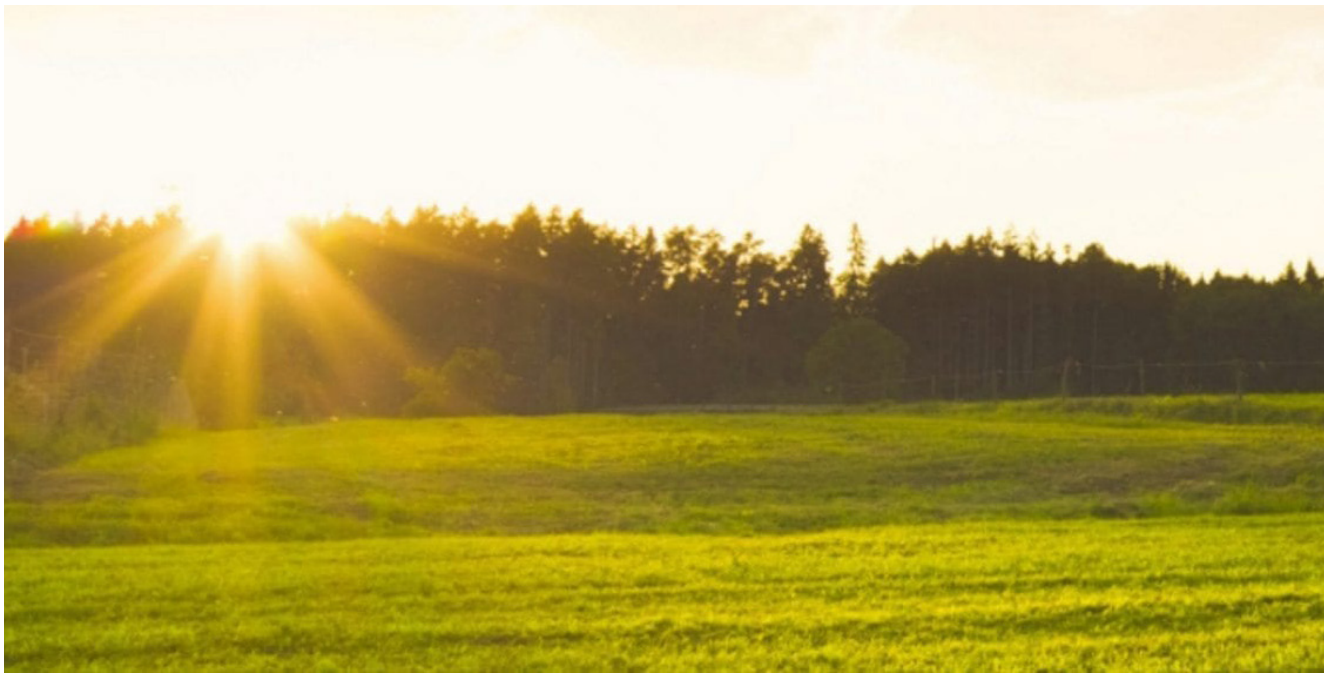
Also, the Federally Qualified Health Center needed to borrow a tent to get its testing site up and running; the existing cross-sector alignment helped put this and other pieces together more quickly.

INSIGHTS FOR ALIGNING

- WICHC offers an example of public health taking the lead among sectors as the convener.
- Specific measures galvanize the group to a common purpose.
- WICHC demonstrates how to creatively finance infrastructure using private investment with matching state legislative dollars.
- Trust established over several years served the group well in expanding broadband during the COVID-19 pandemic.

ALIGNING IN ACTION

YAMHILL COMMUNITY CARE ORGANIZATION



The Yamhill Community Care Organization (YCCO) aligns its organizational goals with multi-sector, community, and government partners using a collective impact framework to address social problems.



Lead organization:

Yamhill Community Care Organization (YCCO)

Lead sector: Health care

Location: Yamhill County, Oregon

Year founded: 2012

Interviewees: Seamus McCarthy, president and CEO, YCCO, and Silas Halloran-Steiner, director of Yamhill County Health and Human Services

LOCAL CONTEXT

YCCO coordinates care for enrollees in the Oregon Health Plan (Medicaid) in Yamhill County and parts of surrounding counties. YCCO is a 501(c)(3) grassroots nonprofit that is locally owned and governed by people in the community, social service providers, and local health care providers.

This coordinated health care delivery model integrates behavioral, physical, and oral health care to achieve the Triple Aim of improving the patient care experience, improving population health, and reducing costs. Oregon's health system transformation included use of a Medicaid 1115 waiver to fund community care organization (CCO) development in 2012.

While one in four county residents is a member of YCCO's Medicaid managed care, much of its work is population-based and benefits schools or the broader community. YCCO is the state's only coordinated care organization awarded an Early Learning Hub by the Oregon Department of Education's Early Learning Division. YCCO oversees the hub and coordinates early childhood services and family supports with local agencies.

SHARED VISION

The Yamhill community health goals are derived from a shared community health assessment and the resulting community health improvement plans. Further, YCCO, the local nonprofit hospital, and the accredited county health department are all required to conduct their own community health assessments.

Seamus McCarthy, president and CEO of YCCO, and Silas Halloran-Steiner, director of Yamhill County Health and Human Services, note the commonality among each organization's identified priority areas. These shared health assessments are used as a tool to bring partners and sectors together around community-identified needs.

The 2019 Community Health Improvement Plan, developed by YCCO's Community Advisory Council, identified oral health, behavioral health, children and families, access to care, trauma reduction and resilience, and social determinants of health (SDoH) as focus areas. Elements of these focus areas address structural factors such as housing, equity, and social supports.

DATA MEASUREMENT

The state sets annual quality metrics that CCOs must meet. These range from prevention and cancer screening goals to pediatric developmental screening measures and opioid prescription limits. YCCO works with providers and partner organizations to meet the 17 metrics defined by the state. YCCO purchased a platform for contracted primary care providers to enable sharing of outcome data for these metrics. Each provider can access the platform and see where it is on a particular metric, as well as identify the individual members who need to receive medical services to meet that metric. Providers can also see how other providers in the network are performing on the metrics.

FINANCING MECHANISMS

In Oregon, health care transformation is based around the Triple Aim. One of the state's strategies to address these aims is an alternative payment methodology: a multitier payment system for primary care clinics that incentivizes the provision of quality, patient-centered, primary care delivery. The quality pool distribution of incentive payments is funded through Oregon Health Authority and federal Medicaid funds.

For the fifth consecutive year, YCCO has received 100% of the funding for meeting the required metrics. Although the YCCO board of directors makes the final payout determination, funds are generally redistributed back to contracted partners to support further innovations in workflow and coordinated care delivery. Between CCO incentive metric dollars and meeting additional conditional measures, YCCO received \$5.5 million in additional payouts in 2019.

YCCO reinvests these funds back into the community through programs such as Service Integration Teams, which address local barriers including helping individuals pay rent or repair a vehicle. The funds also support YCCO's Community Prevention and Wellness Fund, which invests in SDoH, such as improving food security, and supports prevention programs in schools, such as the PAX Good Behavior Game.

GOVERNANCE STRUCTURE

Decision-making power lies with YCCO’s multisector board of directors, which its bylaws state must include representatives from plan health care providers, social service agencies, and early childhood services such as Head Start, Yamhill County Health and Human Services, and early learning providers. The board has four subcommittees: the Early Learning Council, the Community Advisory Council (half of whom are plan members/families), the Quality and Clinical Advisory Panel, and the Community Prevention and Wellness Committee.

According to state requirements, Oregon’s CCOs must work closely and have memoranda of understanding with public health. The 2020 CCO contracts further emphasized SDoH and required that CCOs put a certain amount of their margin or reserves into social determinant investing each year, necessitating cross-sector partnerships.

While partners participate voluntarily, there are structured arrangements in which social service providers may voluntarily participate in YCCO activities and also formally receive funds directed through CCO’s Medicaid payments through the delivery system. Local leaders acknowledge that the combination of contractual obligations and financial incentives, by design, brings together various sectors in partnerships.

INSIGHTS FROM THE COLLABORATIVE

As with building most relationships, in Yamhill, time together and face-to-face time is critical to aligning the sectors.

“We have some common things that these three sectors face around workforce development and challenges within the larger economic forces that Oregon is facing, like housing shortages,” says Halloran-Steiner. “But we also have a lot of different issues that are specific to each sector that we must manage. So, you start from a place of common interest in community health outcomes that we are all interested in, and then after that it takes relationships and trust to develop partnerships.”

With the integration of the Early Learning Hub, YCCO’s structure brings multiple sectors together in a way previously unseen in Yamhill County.

“Having cross-sector engagement created synergy between education and health care that is rare to

find,” says McCarthy.

From behavioral health issues to impaired hearing or vision problems, teachers can make direct referrals to the Early Learning Hub’s community health workers. This closed-loop referral system benefits from the synergy between YCCO and the Early Learning Hub—that is, family assessments can identify other barriers families are having, and YCCO and Early Learning Hub resources can assist through eye examinations, developmental screenings, and so on.

“This, then, makes the classroom more teachable, the teacher less frustrated, the child more successful, and cuts disruptions in the classroom,” says McCarthy.

ALIGNING IN ACTION

The Yamhill Early Learning Hub, within YCCO, brings together multiple sectors — including early childhood and K–12 education; health, human, and social services; and community, business, government, and philanthropic organizations — to improve outcomes for young children and align services into one efficient, effective countywide early learning system.

The YCCO board of directors serves as the governing body for the Early Learning Hub, which is advised by the 24-member Yamhill Early Learning Council. The council also includes cross-sector representation from local school districts, the business community, nonprofits, parents, health care providers, health and social services, early learning programs, county government, tribal leadership, and higher education. The council coordinates efforts and resources among the represented sectors; provides feedback in evaluating family support and early childhood services to ensure positive outcomes and eliminate service duplication; engages families in hub design and parenting strategies; provides advice regarding culturally and linguistically appropriate family engagement; strategizes ways to increase the number and quality of early learning environments; monitors target outcomes; and develops efforts to engage collaborative funding across the philanthropic and public and private sectors.

A tangible example of alignment within the Early Learning Hub is Family CORE, a multidisciplinary group of agencies that uses a single referral form that any provider or community member can use to refer to the entire group. The group meets to review referrals and assigns referrals to the most appropriate resources. Some of the services provided include respite for

parents, parent education, diaper and resource banks, addiction and social support, free meals, mental health services, transportation, and home visiting.

INSIGHTS FOR ALIGNING

- The state's decision to create CCOs as a means to deliver Medicaid benefits through local, community-driven organizations spurred Yamhill stakeholders to imagine what was possible in terms of improving health locally.
- Health care, public health, and social service organizations are all at the table through the board governance, which mandates inclusivity.
- Using incentive payments tied to reaching quality metrics, YCCO can drive revenues back into the community to upstream population health interventions.
- Trust among the sectors has strengthened over time as they have worked together at the same table to drive the CCO's success.



CHAPTER FIVE

Making Aligning Work

**The Aligning Systems
for Health Research Team**

Aligning Systems for Health, supported by the Robert Wood Johnson Foundation and led by the Georgia Health Policy Center (GHPC), focuses on learning from stakeholders across the nation about effective ways to align the health care, public health, and social services sectors to better meet the goals and needs of the people and communities they serve.

The following series of briefs mines the experience of 10 alignment catalysts — experts in areas such as research, financing, and public health — who have been involved with efforts to align health care, public health, and social services organizations.

In fall 2019, our team began conducting quarterly interviews with the 10 experts, focusing on the Cross-Sector Alignment Theory of Change (now the Framework for Aligning Sectors). We concluded the structured interviews in spring 2021; we then invited participants to a virtual, sense-making teleconference with our GHPC research team to assess the emerging themes across the 10 conversations.

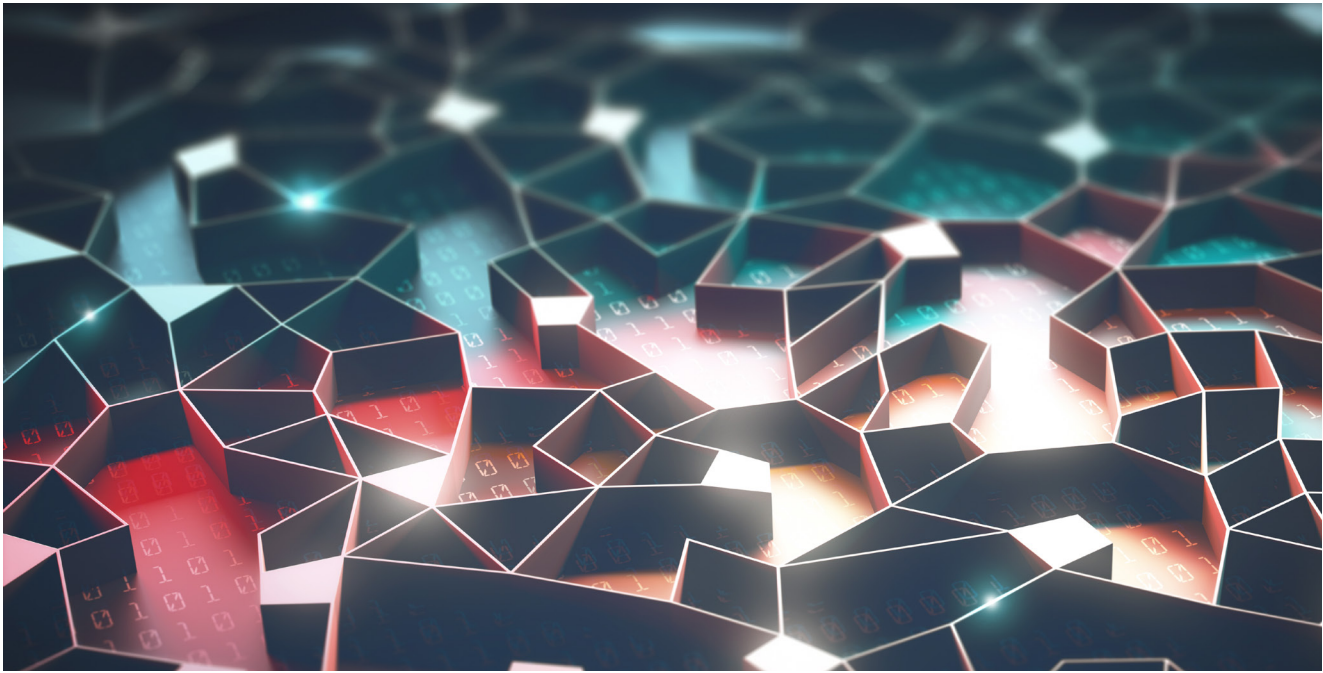
Our initial intent for the Making Aligning Work effort was to gather insights from national catalysts about different components of the framework. Given the triple crisis of the COVID-19 pandemic, the resulting economic struggles, and the ongoing effects of systemic racism, our conversations with the national catalysts evolved over the past 18 months. We describe this evolution, its implications, and the next steps in this chapter's final section.

The catalysts and their organizations are as follows:

- Ella Auchincloss, ReThink Health
- Laura Gottlieb, Social Interventions Research and Evaluation Network
- Mark Humowiecki, National Center for Complex Health and Social Needs
- Jeff Levi, Funders Forum on Accountable Health
- Glen Mays, Systems for Action
- Bobby Milstein, ReThink Health
- Melissa Monbouquette, BUILD Health Challenge
- Gianfranco Pezzino, Center for Sharing Public Health Services
- Alex Quinn, Health Leads
- Claire Tanner, Data Across Sectors for Health
- Brandon Wilson, Center for Medicare and Medicaid Innovation

MAKING ALIGNING WORK

NATIONAL EXPERTS REFLECT ON PURPOSE, DATA, FINANCING, AND GOVERNANCE





This brief focuses on issues related to the Cross-Sector Alignment Theory of Change's four core components of aligned systems: purpose, data, financing, and governance.

PURPOSE

As the examples cited by the interviewees indicate, aligning efforts are often initiated in response to common external factors, such as to overcome a significant challenge (e.g., cost, inefficiency, or inequity, or to make a bigger difference or have a longer-term impact), to further a philosophical or historical value (e.g., service to a vulnerable population), to respond to an external or internal nudge (e.g., funding or legislation) or a new leader's vision, or to address sustainability concerns.

Findings

Aligned systems use a shared purpose to reach across existing organizational boundaries and do something bigger together. The experts reported that this shared purpose can trigger a new way of thinking beyond a transactional approach. This shared purpose, in turn, can become part of a bigger vision. It is still important to be selective and maintain focus, however, even with agreement on the larger vision; without this focus, efforts may become reactionary, and people may lose sight of the goal.

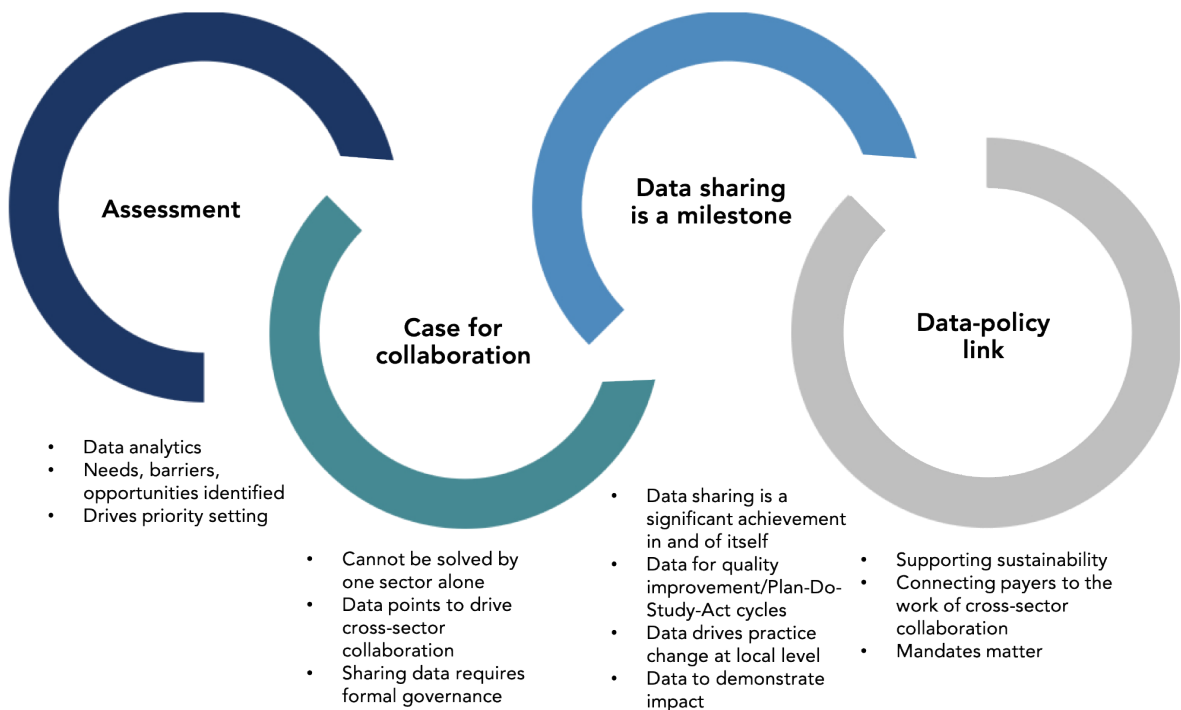
Lessons from Practice

- Although aligning systems can achieve more together than any one organization or sector can achieve on its own, having too big a purpose can make it hard to succeed.
- Avoid the tendency to focus on urgent services and vital conditions rather than on true upstream conditions.
- Strong leaders and trusted partners enable successful alignment, while leadership change can mire progress.
- Vision and purpose are not always fully shared when partners are unequal in power, size, or resources. Further, a shared purpose must be specific and clearly defined rather than simply be the sum of individual stakeholders' visions.

Don't rush the process of obtaining buy-in if the goal is to build lasting alignment; instead go at a pace that fosters partnership.

DATA AND MEASUREMENT

While data is a freestanding, core component of aligned systems, it is inextricably linked to other elements. Data drives collaboration, steering nearly all aspects of aligned systems — particularly purpose and governance.



Findings

Our interviews revealed several patterns in how data is used; although successful collaboratives use data for all of the following purposes, it is not necessarily a linear progression.

Assessment. Data helps identify and build understanding of needs and opportunities, and it can focus priority setting.

Making the case for collaboration. Creating a shared understanding through data brings people together, making the case for collaboration and driving the need for formal governance to direct data sharing among collaborative entities.

Data sharing is a milestone. Data sharing and shared measurement are significant milestones for aligning systems, as both require substantial time, capacity, and resources across organizations. Data informs quality improvement, Plan-Do-Study-Act cycles, and practice changes at the local level. It also demonstrates impact, which can inform financing and sustainability planning.

Highlighting the value proposition. Data provides a way to communicate progress and share learning about the process of aligning systems with payers and policymakers, and it can thereby inform policy decisions.

Lessons from Practice

Data sharing is complex. The challenges, resources, and time required to implement data sharing and adopt a shared measurement system should not be underestimated. Privacy concerns and organizational barriers pose the greatest real-life challenges, even among well-intentioned collaborative partners.

Our interviewees suggested that top-down requirements and mandates could facilitate data sharing, while implementation progress and ongoing use requires trust among partners. Good stewardship practices can enable this trust, as can engaging with local sites and front-line staff early in the process and often to ensure that data is accessible, relevant, and usable for all stakeholders.

FINANCING

To study how aligned systems approach sustainable financing, we applied a three-part framework of sources, uses, and structure.

Findings

As might be expected, examples of collaboratives' financing sources vary substantially

and include Centers for Medicare and Medicaid Services demonstration programs, grants, service reimbursement, and taxes. The uses of funding were also diverse. However, our experts could not identify a single example of on-the-ground aligning efforts that achieved truly sustainable financing. They were also unable to cite examples of cross-sector partnerships that were having meaningful conversations about the structures required to support sustainable financing. This could reflect the lack of maturity of the examined aligning efforts.

Lessons from Practice

While it is a freestanding component of aligned systems, financing is significantly intertwined with data and governance. It is also multifaceted and multidimensional. Even within a local or regional aligning effort, financing possibilities vary greatly from one stakeholder to another. Given this variance even within a local context — as well as collaboratives' seeming lack of maturity in advancing sustainable financing discussions — there are few local examples from which to draw specific, applicable learnings. This, in turn, may hamper the transmission of learnings to emerging alignment efforts.

Based on years of experience working with collaboratives across the nation, the Georgia Health Policy Center and our interviewees believe that shared understanding and trust remain foundational elements that are necessary to address sustainable financing and stewardship. Unfortunately, a number of collaborative initiatives lack these key elements.

GOVERNANCE

The experts we interviewed cited several governance models. *Multisector steering committees* were the most common model cited. While not a formal structure, *charismatic leaders* were often cited as well.

Findings

Interviewees expressed disappointment that top-down governance — whether shaped by a funder, legislation, or regulation — had failed to create an all-play, inclusive structure that includes

the community voice. Often, governance groups include social service representatives rather than those with lived experience. And when they do participate, community representatives tend to serve more in an advisory capacity than to be fully engaged in codesign.

Lessons from Practice

- Staying with one model may not be appropriate over time. As needs change and alignment matures, shifting governance structures could be beneficial.
- As urgency wanes, governance may loosen up.
- Having a charismatic leader or somebody who knows how to work the system can be beneficial, but relying heavily on a single personality may be detrimental and stall momentum during leadership transitions.
- The experts have yet to identify one clear structure that best facilitates decision-making across multiple sectors.

INSIGHTS FOR ALIGNING

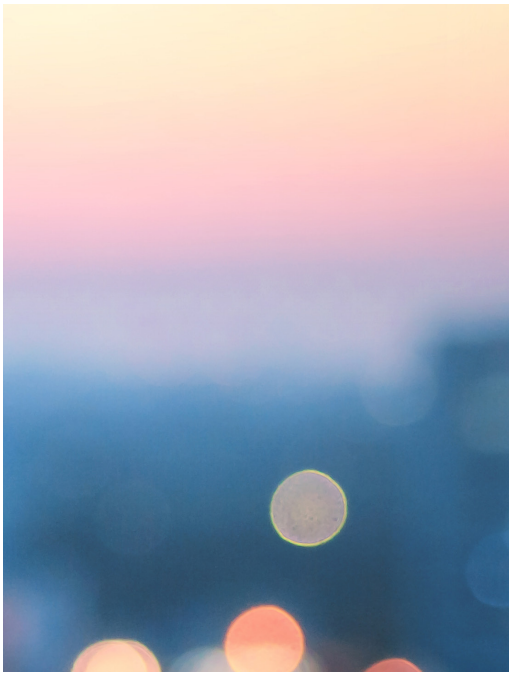
- Although each of the framework's four core elements is independent, they are also entwined in complex ways; this is particularly true of data, finance, and governance.
- We currently lack collective knowledge and meaningful, on-the-ground conversation around sustainable financing and governance structures. This may be due to the relative immaturity of such efforts.
- Variance in resources, organizational capacity, and governance among collaborative partners may slow alignment progress.
- Tension exists between authentic, organic, inclusive, ground-up development of collaborations that align across systems and the jump-start that comes from systemic policy change that creates incentives or conditions that accelerate alignment

- Given the unique local context for financing, infrastructure, and leadership, questions remain about the replicability of specific alignment efforts, and caution is urged about promoting or dictating a prespecified structure.
- Despite enthusiasm for cross-sector alignment — particularly among funders— systematic investment in infrastructure support for alignment is lacking. Advancing these efforts will require significant time and resources.

MAKING ALIGNING WORK

NATIONAL EXPERTS REFLECT ON CONTEXT AND OUTCOMES FOR ALIGNING





This brief focuses on themes related to the context and outcomes of aligning efforts.

CONTEXT: COCREATION, URGENCY, AND HISTORY

Rather than being primarily grant-driven like previous efforts, the majority of current aligning efforts are grounded in community engagement and led by community members, interviewed experts said. Many cited local examples that went beyond community participation and a community voice at the leadership table to formal inclusion in governance and power-sharing arrangements, including board-level involvement.

Interviewees described the context of aligning case examples in a way that paralleled contextual alignment drivers illustrated in the Framework for Aligning Sectors. In many cases, the external context accelerated alignment activity. For example, a health-related community crisis (such as high lead exposure levels) can drive the urgency to align, as can new state or federal policies (such as the Accountable Health Community Model) that offer local alignment efforts new opportunities on which to capitalize.

Experts also repeatedly cited existing capacity factors — such as engaged and committed leadership or an established history of collaboration — as common contextual drivers of successful local aligning efforts. A working history is associated with sustained relationships and established trust, both of which are recognized as enablers of alignment.

OUTCOMES: MOVEMENT ALONG A CONTINUUM

Interviewees described a range of observed outcomes resulting from aligning efforts, with the collaboration itself being most commonly cited. We categorized the various outcomes as follows:

- **Process.** Collaboratives break down the aligning work into key milestones, which builds out the scaffolding essential for alignment. These process-related outcomes include steps associated with building a shared vision and commitment, such as signing a memorandum of understanding and executing data-sharing agreements.
- **Organization or system.** These outcomes include capacity-development and process-improvement activities that further strengthen the infrastructure needed for enduring alignment.

- **Impact.** Some established initiatives have achieved measurable outcomes, including fewer sick days, decreased emergency department admissions, and an increased supply of healthy housing stocks.

Interviewees recognized that outcomes evolve with the duration and intensity of alignment activities; they described the alignment continuum as progressing from transactional activities to a true interdependency across sectors. Collaborative relationships require working through process and organizational outcomes to establish a mutually beneficial infrastructure, which is needed to achieve the more permanent, formalized interdependency that is the pinnacle of alignment across sectors.

INSIGHTS FOR ALIGNING

As existing examples attest, alignment is possible across the health care, public health, and social services sectors.

Successful aligning initiatives include the framework's four pillars: purpose, governance, data, and sustainable financing mechanisms. The tools to build these pillars play a key role in supporting aligning for the long term:

- The structure supporting the alignment should follow the framework strategy.
- A shared-use case can be a strong driver for multisector activity, while a vision that is too broad can limit forward momentum.

The partnerships needed to sustain aligning are complex and multifaceted:

- Leaders and partners involved in local aligning can extend beyond the three sectors, and partnerships can benefit from a history of collaboration.
- While it is imperative that the three sectors are equally represented and valued, each sector may have its own distinct resources, roles, and motivations for participation.
- There is a difference between organizations aligning and sectors aligning. The health care, public health, and social service organizations participating in a local alignment

initiative may not fully represent the voice of their entire sectors.

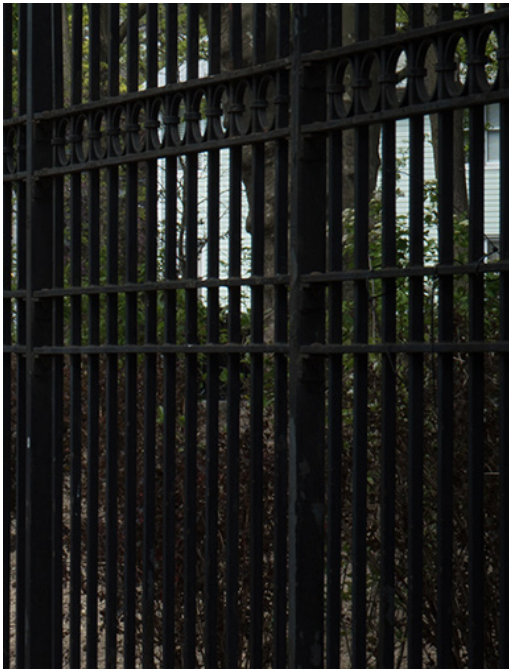
Establishing an alignment that will endure requires time, trust, and patience:

- An adaptive mindset and a pioneering attitude are necessary to navigate the complexities of a multisystems orientation.
- Moving from conceptualization to action requires strategic thought and problem-solving capabilities.

MAKING ALIGNING WORK

AN EARLY LOOK AT COVID-19'S IMPACT ON CROSS-SECTOR ALIGNMENT





This brief focuses on very early observations of how the COVID-19 pandemic is impacting communities aligning health care, public health, and social services using Framework for Aligning Sectors components such as internal capacity; urgency; shared purpose, data, financing, and governance; community engagement; and a focus on equity.

STRESS TESTING CROSS-SECTOR ALIGNMENT

A stress test measures a system's strength or stability when handling conditions beyond its normal operating capacity. Conducting stress tests in a simulation can be validating — or it can highlight a system's weaknesses. The COVID-19 pandemic is no simulation. However, it is serving as a real-time experiment to determine whether communities with more cross-sector alignment elements in place are better positioned for response and recovery; it can also draw attention to their weak points.

Interviewees acknowledged that it is too early to assess the pandemic's overall, long-term impact in terms of how these “more aligned” communities are faring compared to communities not working toward cross-sector alignment. However, the experts did highlight the ways in which the COVID-19 response can be understood through the framework's lens. The evidence emerging shows positive and negative examples for each framework component, depending on the local context.

Purpose

The pandemic has given communities an obvious, urgent reason to unite around a common cause. However, it also risks their pivoting away from core efforts to create a shared sense of purpose around health-related social needs. These needs are related to food insecurity, housing instability, and domestic violence, and they have only grown more intense during the pandemic. It remains to be seen whether communities can pivot back to supporting such broad community needs — possibly in an even more comprehensive fashion.

Governance

Established, purposeful processes, relationships, and trust are enabling aligned organizations to pivot quickly toward emerging needs. That said, patience might be lacking for existing or emerging governance processes, which could be pushed aside in favor of a quicker response.

Data

Data-sharing agreements are being fast-tracked in some local and regional initiatives, and previously reticent organizations across the sectors are now eager to join. However, under-resourced organizations may have limited capacity to continue their participation.

Capacity

The pandemic will strain financial capacity across all three sectors. It remains to be seen whether organizations and communities that have cross-sector alignment elements in place are better positioned to leverage new funding opportunities than those that lack this alignment. Another question here is whether communities with recent experience with disasters — such as hurricanes and wildfires — have greater capacity to activate and quickly mobilize than those without such experiences.

Community Engagement

Some organizations and collaboratives shifted quickly to virtual engagement, focusing on the most effective ways to support virtual community participation. Examples here include using the telephone when Internet access was limited, providing tablets, and using platforms that were more familiar and accessible to community partners. Some interviewees were concerned, however, that meaningful community engagement was decreasing due to disruptions to regularly scheduled in-person meetings, competing demands on front-line workers, and disparities in the ability to access technology. Further, if prepandemic community engagement did not already exist, it is difficult to create it in a virtual environment.

THE IMPACT ON CROSS-SECTOR COLLABORATIONS

Although it seems likely that sectors are leveraging existing relationships to rapidly address emerging pandemic-related needs, it is too soon to determine the actual outcomes of response coordination or its success in meeting health and social needs.

National examples show accelerating cooperation among competing organizations, new partners being brought to the table, and a re-engagement with previously less-involved partners. The pandemic continues to make the interconnectedness of factors affecting health more visible. Some experts expressed hope that these examples of expanded relationship building will lay the groundwork for future aligning efforts. Other interviewees noted that shifting organizational priorities, resources, and capacity could hamper participation in core alignment-building efforts.

Health Care

Initially, the COVID-19 conversation was framed primarily as a health care issue, focused on critical care needs for infected individuals and personal protective equipment for front-line workers. This focus on immediate needs placed the power in and attention on health care, making discussions around longer-term impact and social needs more challenging.

Public Health

Interviewees expressed optimism that this moment in time may bring greater understanding about the need for population-level health initiatives, as well as greater appreciation of the role of public health.

Social Services

Interviewees expressed greater concern about the social services sector's ability to participate in cross-sector alignment efforts after the pandemic. This sector is more dispersed than the other sectors, and its leadership is less visible at the state and national levels. However, the need for social services — particularly in light of the pandemic — is accelerating. The challenges of meeting health-related social needs virtually are being increasingly recognized, as is the uncertainty about social service organizations' financial capacity as communities move beyond the acute phase of the response.

INEQUITIES ARE OF GREAT CONCERN

The pandemic clearly underscores population-level health inequities in terms of those most infected, critically ill, and dying from coronavirus. However, two other potential inequities exist that may impact future participants in building aligned systems:

- **Imbalances between sectors.** Historically, underlying power differentials have impacted cross-sector work. Because the pandemic is mirroring — and perhaps exacerbating — these existing dynamics, it reinforces the likelihood that money will be spent on acute conditions rather than preventive investments.
- **Vulnerable populations.** Social distancing and remote operations have equity ramifications in terms of the meaningful engagement of community members. As we design the COVID-19 recovery and aligned future infrastructure, we must ensure that we hear and heed the voices of essential workers, people with comorbidities, and people unable to access virtual technologies.

Still, the experts saw a potential silver lining in the pandemic: it is increasing public awareness of equity, which could fuel efforts to address disparities. We have an opportunity to translate this increased understanding of the social determinants of health — and their connections to health and public health — into enhanced engagement.

INSIGHTS FOR ALIGNING

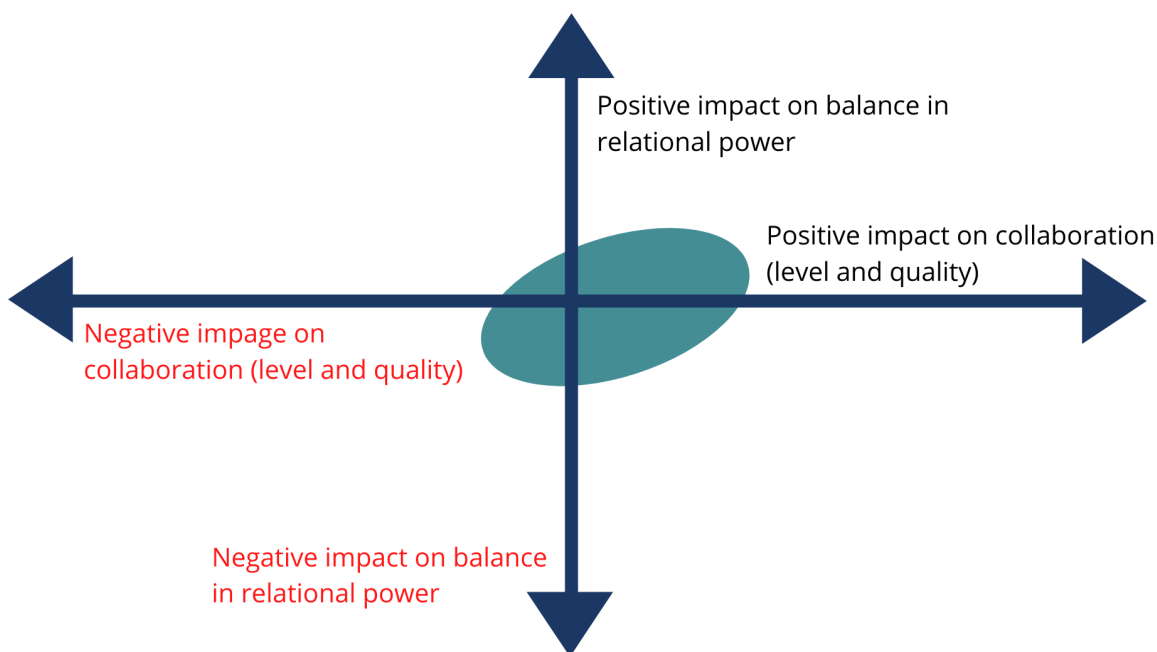
The interviewees all agreed that it is too soon to tell whether having cross-sector alignments in place is a protective factor for communities; proclaiming clear takeaways for aligning organizations and leaders is thus premature. However, participants were clear about the trends to watch.

Shifting Dynamics

Building aligned systems involves more than collaborative planning or a single joint project.

It requires fundamentally new ways of thinking and working together across sectors — including the development of core cross-sector components, such as shared purpose, data, governance, and financing. To realize this in an era of COVID-19, interviewees said they are examining both the evolution of relational power between sectors and their collaborative activities. Shifts in these dynamics may be early measures of the ability to engage in building aligned infrastructure during the COVID-19 recovery phase.

Based on this quarter’s interviews, the dynamics of relational power and collaboration remain fairly close to the origin (as indicated by the green oval). Experts agree an environment that fosters alignment would be a movement toward the star, whereas movement toward the square would indicate a nonsupportive environment for building aligned systems.



Identifying and Leveraging Opportunities

The COVID-19 pandemic is unprecedented and represents a profound learning opportunity. Communities working to develop aligned systems have an opportunity to effectively consolidate pandemic-related learnings that would benefit participants across sectors. Those with the capacity

to participate in building cross-sector alignment elements presumably would be the more immediate beneficiaries of these learnings, which could inform response and recovery efforts that support greater health equity and innovation.

LOOKING FORWARD

Given the early stage of the pandemic response, Aligning Systems for Health will re-examine how communities and organizations engaged in building cross-sector alignment elements are faring during the COVID-19 response and recovery. Among the specific questions we will examine are the following:

- Does the existence of cross-sector alignment’s core elements (or efforts to build them) improve response to and recovery from the COVID-19 pandemic?
- Are those communities with strong existing cross-sector collaboratives better positioned to receive funding for response and recovery?
- Many community-level efforts and cross-sector collaboratives are directly or indirectly subsidized through local health care systems; now that the health care sector has serious resource constraints, what long-term impacts might be expected?
- What is the impact of having local variations in cross-sector responses to the pandemic — as well as variations in who is leading the responses?
- Where health disparities exist for COVID-19 health outcomes, can cross-sector alignment alleviate the causal factors?

MAKING ALIGNING WORK

NATIONAL EXPERTS REFLECT ON SYSTEMIC RACISM AND CROSS-SECTOR ALIGNMENT





This brief focuses on the themes emerging from initial conversations about how cross-sector alignment might address systemic racism.

A NOTE ABOUT LANGUAGE

Given the rapidity with which the issue of systemic racism has become a part of the national public dialogue, our interviewees were in different states of readiness to discuss systemic racism and their roles at the individual, organizational, and system levels. These conversations are difficult; they are further hampered by a lack of shared understanding and agreement around the nuances of language.

Both “systemic” and “structural” racism describe how racism is normalized as part of historical and ongoing policy and practice within society and organizations; we chose to use the term systemic racism as it acknowledges racism is present in all systems, including those that are the focus of Aligning Systems for Health.

ALL SECTORS ARE CHALLENGED BY SYSTEMIC RACISM

All 10 interviewees acknowledge that systemic racism exists, even in organizations and systems that are working hard to enhance community well-being. While sentiment among interviewees varies from hopeful (because new opportunities have emerged to solve a long-standing problem) to frustrated (because developing a more inclusive process still may not translate into meaningful change), common themes emerged.

Racism is present in processes, policies, and practices at the individual, organizational, and systemic levels. Some interviewees expressed concern that focusing on structural manifestations of racism allows individuals to avoid self-examination in favor of seemingly more distant institutions.

The systems and organizations participating in local and regional cross-sector alignment efforts are not immune to these dynamics. All three sectors involved in Aligning Systems for Health — health care, public health, and social services — have vulnerabilities, as do other partnering sectors such as education, criminal justice, and housing.

Aligning across sectors may help address systemic racism by helping to create pathways for different conversations, new perspectives, better listening, and a way to challenge the status quo. The Framework for Aligning Sectors may be able to help guide this action, such as by

realigning investment in organizational capacity, examining governance, and thinking differently about community voice.

KEY QUOTES FROM INTERVIEWEES

- “Racism is present in processes, policies, and practices at the individual, organizational, and systemic levels.”
- “This work is hard, but it has to be done.”
- “No single organization or system can fix this.”
- “Aligning across sectors may help address systemic racism: The process of aligning across sectors may help create pathways for different conversations, new perspectives, better listening, and a way to challenge the status quo.”
- “There is a tension between the social window that is opening and how long it takes to make real progress.”

WHY DOES SYSTEMIC RACISM MAKE CROSS-SECTOR ALIGNMENT HARD?

Trust is foundational both to building cross-sector alignment and to addressing systemic racism. That systemic racism, however, can make it difficult to develop these trusting relationships across partners and to build the lasting structures needed to align across sectors and ultimately improve health equity. There are other challenges here as well.

There is no recipe. Where to start can be daunting. How do we prioritize? Which conversation? Which policy? Do we have the right people and pieces in place?

Real change takes time. While sensitive organizations and funders push for language change, real, meaningful change takes time. Will the momentum be sustained beyond the current sense of urgency? Are the decision-makers listening? Again, these issues involve fundamental questions about leadership and trust.

Addressing systemic racism is emotionally challenging. Addressing systemic racism is not something that can be compartmentalized; it touches all facets of life, not just work. Individuals are struggling to understand their role in the status quo and in the work ahead: Are they complicit, or a change agent? Some individuals who understand that addressing systemic racism is the right thing to do currently feel as if they are “living in a state of perpetually walking on eggshells.”

No single organization or system can fix this. It has to be clear to everybody that change is needed, and people and organizations need the right language, skills, and tools to participate in these conversations. Not all people, however, are at the same level of readiness to participate. Substantial trust and collaboration across sectors are needed to foster both new conversations and new ways of thinking to challenge the status quo. Traditionally, the status quo has given certain groups disproportionate privilege and power. It is difficult to change a system or systems; before the next level of change can happen, shifts in baseline parity among partners might be required.

HOW MIGHT CROSS-SECTOR ALIGNMENT INFORM EFFORTS TO ADDRESS SYSTEMIC RACISM?

Various factors in cross-sector alignment can impact the way systemic racism is addressed.

Factors Affecting Urgency

Urgency and intentionality must be balanced; the current feeling of chaos is not good for building long-term solutions. Sustainable, impactful solutions require accountability, intentionality, and follow-through — and yet pressure exists to take advantage of the existing window of opportunity. A balance is needed.

Factors Affecting Internal Capacity

Individual organizations seeking to play a role in dismantling systemic racism are starting within their own institutions. Interviewees say that workforce development, funding decision-making, data-sharing capacity, and a leadership assessment are good places to start.

Factors Affecting the Core Elements

Local context influences the core elements of aligned systems, and yet there is a certain dynamism across the four elements. Interviewees note that organizations can address systemic racism in each core area as they work to establish it:

- **Shared purpose** must be reflective of community voice and community-identified needs.
- **Data** is reflective of power and control, and a digital divide exists across sectors.
- **Resources** have long been recognized as a rate-limiting factor when building aligned communities. Well-resourced organizations often are the ones with the capacity to perpetually win additional funding, however, which further perpetuates power imbalances.
- **Governance** is often reflective of who currently holds power. Rebuilding aligned governance around true power sharing — and as an accountability mechanism — could be a positive way for aligned systems to address systemic racism.

Factors Affecting Success

Softer elements also play a big role in developing aligned systems and addressing systemic racism:

- Trust as an end point requires trustworthiness as a starting point. Where trust is long-standing, people and organizations may be able to delve deeper and quicker into these difficult conversations.

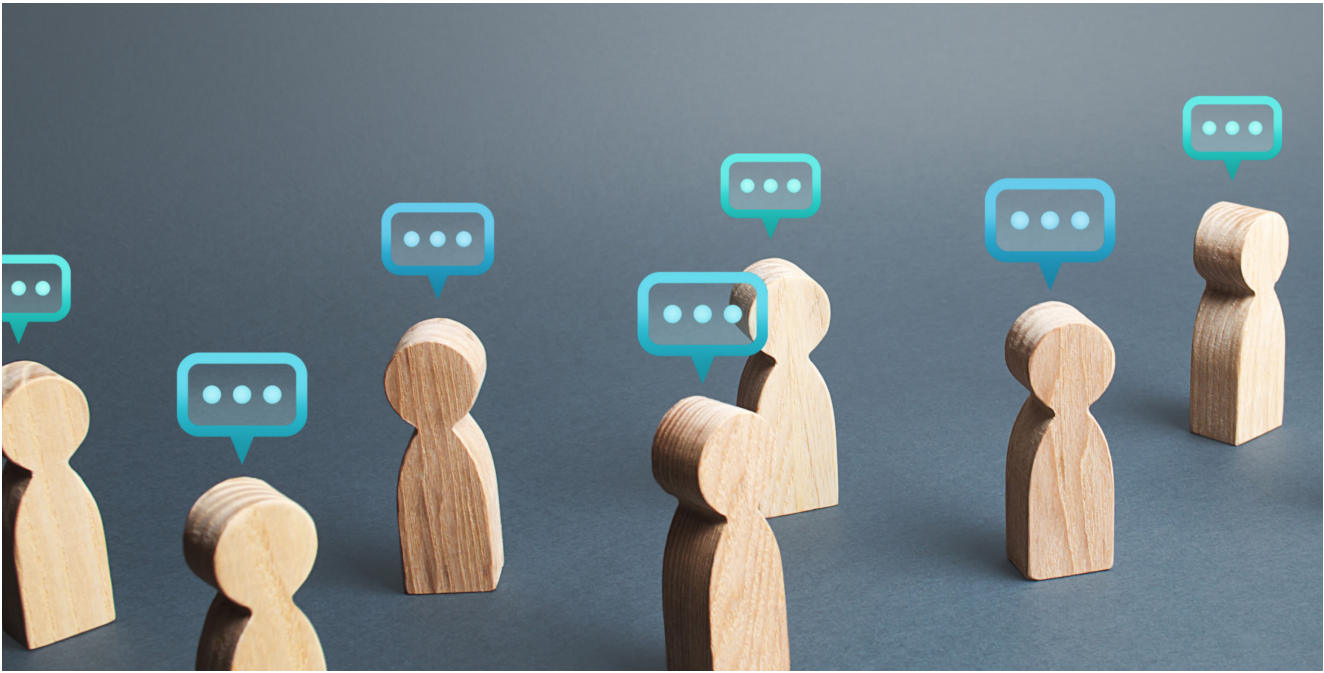
- Community engagement must be genuine — not merely a seat at the table, but a true partnership with shared power. The additional challenge is that in the COVID-19 era, there are competing priorities, including the need to meet basic economic and health needs.
- A strong, visible backbone organization is important to carry out this work.
- Having the right mindset is central to participating in challenging conversations, reflecting deeply, and re-envisioning communities.
- Fundamental to this mindset is recognizing that the experience of others counts.

RESOURCES

Our catalysts suggested the following resources for exploring this topic further.

- Neighborhood Funders Group, “A Framework for Community Power Building”: www.nfg.org/sites/default/files/resources/Democratic_Development_Report_Framework_Graphic.pdf
- Funders Forum on Accountable Health, Building Equity and Community Accountability into Pandemic Response and Recovery: [https://accountablehealth.gwu.edu/sites/accountablehealth.gwu.edu/files/Council%20Proposal%20final_%20072420a%20\(1\).pdf](https://accountablehealth.gwu.edu/sites/accountablehealth.gwu.edu/files/Council%20Proposal%20final_%20072420a%20(1).pdf)
- Vu, “Have Nonprofit and Philanthropy Become the ‘White Moderate’ That Dr. King Warned Us About?” <https://nonprofitaf.com/2020/06/have-nonprofit-and-philanthropy-become-the-white-moderate-that-dr-king-warned-us-about>
- Aditi Vaidya, “Walk With Us: Building Community Power and Connection for Health Equity,” Culture of Health blog, Robert Wood Johnson Foundation: <https://www.rwjf.org/en/blog/2019/08/walk-with-us--building-community-power-and-connection-for-health-equity.html>
- PolicyLink, “A CEO Blueprint for Racial Equity”: <https://www.policylink.org/resources-tools/ceo-blueprint-for-racial-equity>
- Ruha Benjamin, Race After Technology: <https://www.ruhabenjamin.com/race-after-technology>
- Wendy Ellis, “A Historical Examination of Racism in the United States and Its Impact on the Black Community”: <https://www.mathematica.org/events/a-historical-examination-of-racism-in-the-us-and-its-impact-on-the-black-community>
- Equity in the Center: <https://www.equityinthecenter.org/wp-content/uploads/2019/04/Equity-in-Center-Awake-Woke-Work-2019-final-1.pdf>
- Racial Equity Institute, The Groundwater Report: Building a basic understanding of structural racism: <https://www.racialequityinstitute.com/groundwaterapproach>

MAKING ALIGNING WORK
ADAPTIVE FACTORS



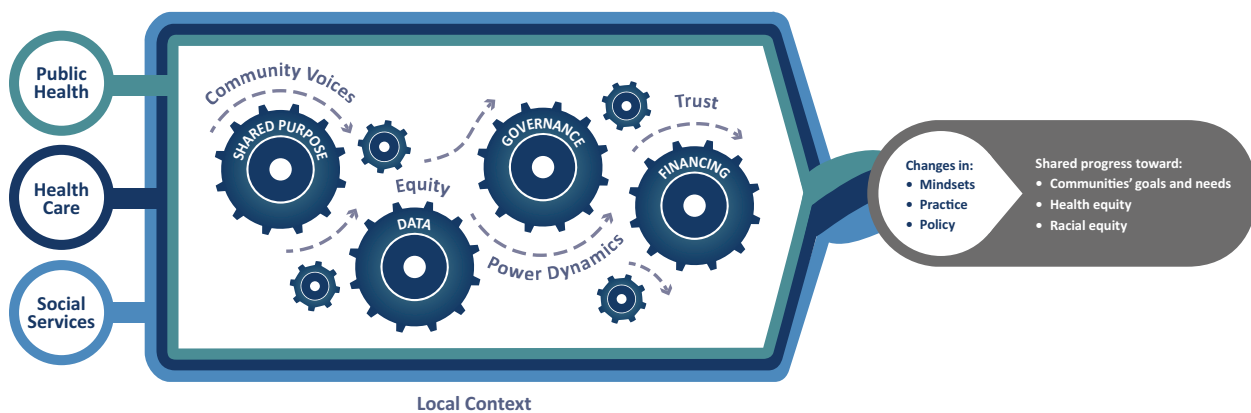


This brief focuses on the newly revised Framework for Aligning Sectors, including how its four adaptive factors help to ensure the success and sustainability of aligning, how the core components and the adaptive factors interact, and how the adaptive factors relate to outcomes.

THE ADAPTIVE FACTORS

As Figure 1 shows the Framework for Aligning Sectors has four adaptive factors.

Figure 1. The Framework for Aligning Sectors



Trust

Trust, both between organizational partners and with the community, is critical to every aspect of aligning — and particularly to each of the core components. Without trust, shared governance and financing, data sharing, and common purpose are not possible. The challenge remains identifying best practices for building and restoring trust.

Community Voices

Community voice has to be built. Our interviewees recognized that more-inclusive collaboratives foster a cycle of inclusion and further expand community voice. Having representatives from community-based organizations, however, is not the same as having community members at the table, and community engagement is not the same as community leadership. Listening to the stories of those with lived experience is a starting point; making space for them to actively participate in the collaborative may organically build capacity for power sharing.

Power Dynamics

Power dynamics surface in multiple ways, and they are often connected to the flow of money. Between the sectors, power dynamics exist between health care and social services. There are also individual power dynamics between organizational leaders and community leaders and members. Power dynamics overtly influence the core factors of financing and governance and have a known interplay between the adaptive factors of community voice, trust, and equity.

Equity

Our conversations with catalysts revealed that it is difficult to look at equity independently of the other adaptive factors. For example, organizations that are attentive to power dynamics likely have equity as an outcome. Taken together, the adaptive factors are part of a new focus on power that includes social justice and eliminating systemic racism. These factors are interconnected, and they all matter when trying to accomplish health equity and racial equity.

EXAMPLES OF INTERACTIONS

While not an exhaustive list, interviewees surfaced several themes illustrating connections between the core components and adaptive factors.

Data, Trust, and Governance

Data sharing can be a major source of power issues and distrust. Governance can address issues such as who owns the data, how data is collected and by whom, who participates in data interpretation, and what happens as a result of that interpretation. Failure to address these issues can derail aligning efforts.

Governance, Equity, and Trust

While governing bodies do not have solutions per se to address many of these challenges,

racial health equity should be built into the governance structures in order to build trust among community members that they are going to be listened to.

Equity, Community Voice, and Power Dynamic

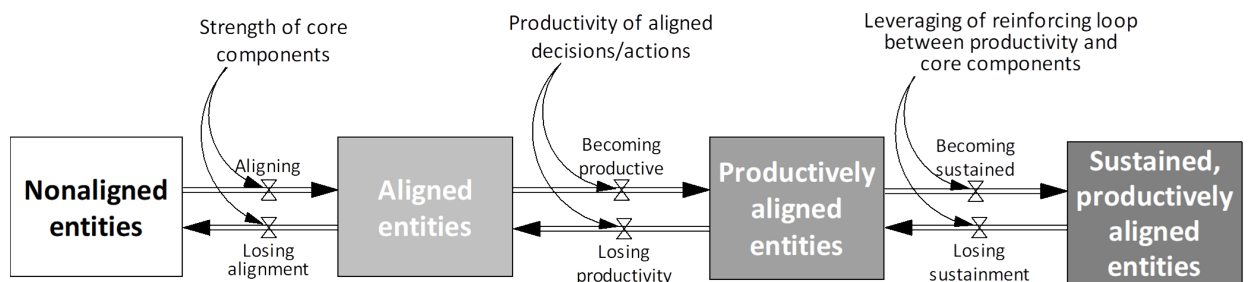
When racial equity and health equity are sincere goals, there is a heightened attention to navigating power dynamics. Meaningfully engaging community voices in a cross-sector collaborative requires both recognizing that everyone has value and adopting different ways of communicating with each other to get things done.

HOW CORE COMPONENTS AND ADAPTIVE FACTORS INFLUENCE ALIGNING SUCCESS

Building the core components of aligning across sectors and strengthening adaptive factors provide a foundational structure for sectors to work together in new ways. Doing so may also enhance the sustainability of efforts and create shared movement toward meeting communities’ goals and needs.

To begin thinking about how to depict the interplay of core components as influencers of aligning, our catalysts engaged in a dialogue with a systems expert. Among the results was some consensus that aligning sectors occurs along a continuum — ranging from nonaligned entities coexisting in a community to entities that are aligned in a sustained and productive manner (see Figure 2). Movement along this continuum can be bidirectional, meaning that certain factors can accelerate or decelerate rates of alignment.

Figure 2. The Continuum of Aligning Sectors



The Framework for Aligning Sectors theorizes that aligning increases as health care, public health, and social services develop the four core components and strengthen the adaptive factors; similarly, aligning weakens if these elements are not practiced.

With these building blocks in practice, aligning entities become productively aligned to the extent that their alignment results in effective decisions or actions that otherwise would not have occurred or would have been less effective. Productivity can increase or decrease, depending on the extent to which entities remain in alignment.

The successes (proximal or long-term) that result from productively aligning entities can create reinforcing loops that leverage their effectiveness to further strengthen the core components. Showing results can strengthen shared purpose, reinforce the value of data sharing, inspire new forms of shared funding, and feed into shared governance. This process, in turn, furthers productivity. The reinforcing feedback loop thus influences sustainment in a virtuous cycle. However, the reverse can also be true: failures to productively align can create a vicious cycle, which further weakens not just productivity but also the ability of the sectors to maintain the core components and adaptive factors necessary to create the foundations of alignment.

CONCLUSIONS

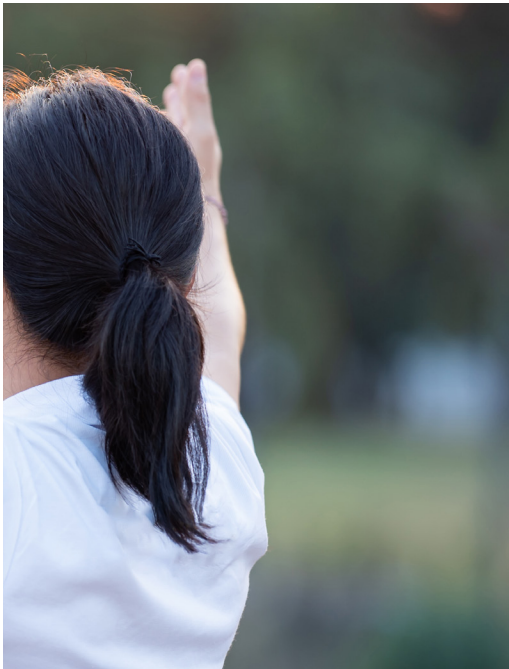
Mapping the states of aligning may overly simplify the interconnection among the core components and adaptive factors by assuming that such elements are either fully in place or absent. In the real world, collaboratives may develop some elements more rigorously than others, and they may need support in diagnosing such strengths and finding best practices to build capacity in weaker areas. Also, further assessment is needed to determine how communities can move across the spectrum toward sustained productive alignment if some core components or adaptive factors are not fully developed. Is there a minimum threshold necessary? Are some elements more important? Must some come first?

Aligning Systems for Health will continue to explore the interplay between the core components, adaptive factors, and outcomes of aligning, as well as how these factors can positively or negatively create feedback cycles that impact the success and sustainability of alignment efforts.

MAKING ALIGNING WORK

REFLECTIONS AND NEXT STEPS





In addition to asking about their general insights into challenges and lessons learned, we concluded our catalyst interviews by asking them to reflect on the learnings and themes that have emerged from their aligning work over the past 18 months and, more specifically, in response to the COVID-19 pandemic.

GENERAL INSIGHTS

Following are five broad insights gathered from the interviews across the Making Alignment Work effort.

Context and Outcomes

A tension exists between collaborations that organically develop and align across sectors and those that are jump-started based on systemic policy change that offers incentives or conditions that accelerate the aligning process (e.g., systemic investment in the infrastructure to support it).

Core Components

The original Cross-Sector Alignment Theory of Change (now the Framework for Aligning Sectors) highlighted four core components of aligning — shared purpose, data, financing, and governance — that are actually present in successful aligning initiatives. Currently, however, we lack collective knowledge and conversation around sustainable financing and governance structures to support aligning across sectors.

Adaptive Factors

There is growing recognition that adaptive factors — that is, trust, community voice, equity, and power dynamics — can help to sustain partnerships in long-term cross-sector alignment efforts. These adaptive factors have a complex and multifaceted relationship with the four core components of aligning.

Systemic Racism

Even in organizations and systems dedicated to enhancing community well-being, inequities exist. Aligning across sectors may help create pathways for different conversations, new perspectives, better listening, and ways to challenge the status quo. Further, each of the core components and adaptive factors associated with aligning can be structured to help address the effects of systemic racism.

REFLECTIONS ON THE PAST 18 MONTHS

Our interviewees highlighted several general challenges and learnings related to their aligning efforts over the past year and a half.

Aligning Across Sectors Is Complex

Aligning across sectors is part of a larger story of systems change and of learning how to work across differences — of sector, of race, and of place. Successfully and sustainably aligning across sectors requires a complex mix of partners who are willing to work differently. But, as is widely recognized, there is no recipe to follow.

It is easy to recognize the needs of people and communities that should be addressed; how to actually put that into practice and action and move aligning forward is the hard part. Aligning across sectors involves coordinated, adaptive stewardship in a dynamic environment. It is more complicated than the individual core components or adaptive factors would indicate.

The External Environment Matters

Externally, the environment is rapidly evolving. The question is thus shifting to how the sectors can jump-start aligning when all necessary components or capacities may not be optimally in place. Can communities scale aligning efforts to meet external circumstances — funding opportunities or emerging community needs — in a way that positions aligning as a built-to-last solution for restructuring in a post-COVID environment?

On a related note, it is difficult to use “just carrots” to incent sectors to work together in fundamentally new ways. We may need a carrot-and-stick policy approach to make long-term investments in infrastructure and to reflect how important it is to bring these alignment efforts to fruition.

Organizations Need Internal Commitment

Well-documented examples show how the turnover of a leader or champion within an organization or project sets back collaborative efforts. Thus, it is critical to build an internal

organizational culture that fosters and values system change so that the inevitable leadership change does not stall progress.

To achieve this, the will of an individual or small group must become an organizational imperative. When this imperative is built into organizations across sectors, it fosters more widespread acknowledgment of shared goals and gives the work of organizations greater congruence, naturally enabling aligning.

Need Can Drive Aligning Across Sectors

As the saying goes, necessity is the mother of invention. While the needs of some communities have been overlooked for generations, the COVID-19 pandemic shined a not-to-be-missed spotlight on them. Emerging needs resulting from the pandemic itself, related economic challenges, and the long-festering implications of systemic racism forced a response. Collaborations emerged out of necessity. What remains to be seen is whether the work can grow and new partners can find innovative ways to sustain long-term collaborative efforts.

THE IMPACT OF COVID-19 ON ALIGNING

At the pandemic's outset, our biggest question regarding Aligning Systems for Health was whether we would find evidence for or against the hypothesis that having the components of cross-sector alignment in place would improve readiness for, response to, and recovery from the COVID-19 pandemic. Following are a few reflections on how COVID-19 impacted our catalysts' efforts to align.

Collaborative Efforts Are Increasing

Catalysts report a proliferation of collaboratives forming over the past year. Such efforts are viewed as a reaction to the COVID-19 pandemic and its downstream impact, yet the policy environment did not keep pace with this need for change. The result is a situation in which aligning

efforts are responding to their broader environment, but they may not have in place all of the necessary conditions to thrive for the long term.

Public Distrust of Institutions Is Profound

There is widespread distrust for almost any system right now. This lack of public trust is hampering the ability of public health agencies and collaboratives to respond to and rebuild from the pandemic. Aligning Systems for Health recognizes that community voices must be at the forefront of efforts to shift power and align across sectors. Still, practical questions remain about how to develop a common language to promote engagement and center transparency and equity in all processes, including data sharing.

Can This Crisis Offer Opportunities for Systems Change?

While the pandemic itself is a once-in-a-century event, it highlighted myriad systemic problems and amplified generations of inequities. There is now a real tension between loss and the prospect of renewal, as some people see the pandemic's disruption of day-to-day life as an opportunity to make needed organizational, cultural, and systems change.

The pandemic has been a needed wake-up call about population health and the socioeconomic factors that drive it, but it also has served to magnify political division in the United States and the recognition that opportunity is not uniformly shared. It remains to be seen whether these realizations are a crisis response or will usher in a period of renewal and a deeper recognition of our interdependence.

How Will Public Health Emerge?

According to our interviewees, the pandemic illuminated the consequences of decades of underinvestment in public health infrastructure. The federal government is now investing \$7.6 billion to rebuild and modernize public health capacity. Does this investment provide an opportunity for the public health sector to emerge from the pandemic as a potential leader of cross-sector alignment efforts? Possibly. But our catalysts also expressed concern that public health

missed an opportunity to demonstrate its true value, as there was often tension between public health officials and elected policymakers. The pandemic has also left local public health staff members frustrated, underappreciated, and overworked — and many are departing.

OBSERVED CHANGES OVER THE PAST YEAR

Since March 2020, the crises in health care and the wider social and political worlds have impacted alignment efforts in various ways.

Funding Aligning Efforts Remains Complicated

Developing sustainable financing for aligning has been a challenge both before and during the pandemic. Many communities were able to take advantage of the enhanced funding opportunities, especially for public health, that the pandemic created. Often, the immediacy of the challenge necessitated collaboration, but whether these partnerships are built to last — and whether the pitch for cross-sector investment is perceived as valuable — remains uncertain.

Multisector Collaboratives Are Embracing Bigger Goals

Many examples of multisector collaboration target only a specific population. However, catalysts report that in the past few years, leaders of efforts to align sectors are seeking to have a larger population-level impact beyond just, for example, hospital readmissions or early childhood. Indeed, initiatives are increasingly being designed to address outcomes at the community level rather than the individual level.

Sustaining the Urgency Created by a Crisis

The pandemic created the opportunity for rapidly developed partnerships between the public and private sectors, as well as between nonprofit organizations and government. How can these collaborations be sustained after an emergency response? Will these efforts be sustainable? Will the influx of COVID-related money really change how sectors work together for the long term?

The recently passed relief bill will bring more large amounts of money into communities for mental health, public health, and food. The challenge is to deploy the resources in a way that meets urgent needs and also increases capacity for aligning across sectors.

WHAT'S NEXT

Since fall 2020, the Aligning Systems for Health team has focused our resources on supporting ways to measure key factors in the cross-sector alignment field. The goal of this work is both to provide the field with tools to measure the Framework for Aligning Sectors concepts (such as shared governance and community voice) as well as to further understand how best to measure aligning's impact.

Our conversations with catalysts over the past 18 months have been incredibly insightful and valuable to our developing learning around cross-sector alignment. We continue to identify and pursue ways to keep this panel engaged in the learning. We are also exploring ways to bring community voices into this broader learning process; doing so will enhance our learning through input from those who will ultimately benefit from system change.



CREATIVE
COLLABORATION

BE
TEAMWORK

MARKETING
ANALYTICS

EMPLOYEES TOGETHER

US



CHAPTER SIX

Learning from Rapid-Cycle Research Grants

Race, poverty, poor housing, and food insecurity play key roles in shaping health outcomes at the population level. Failure to address these key social determinants of health (SDoH) creates a vicious cycle: low-income families struggle with poor health, while also spending a higher proportion of their earnings on medical expenses than other income groups spend.

Coupling social services and community resources with affordable care in safety net hospitals helps mitigate the impact of socioeconomic status on health outcomes. By mobilizing and working together, practitioners can better align systems to address people's unmet needs while also preventing expensive episodes of care. Accepted solutions include providing housing vouchers, which stabilize families in their home and reduce emergency department visits; maternal home visits, which improve birth outcomes and reduce adverse childhood experiences; and community health workers, who help patients and caregivers navigate the complex and disjointed health and social care systems.

Despite awareness of these solutions and their benefits, the health care sector continues to struggle with identifying health-related social needs and directing patients to appropriate and trusted community partners that can provide such services. Indeed, research points to a lack of alignment between health care and community-based resources and insufficient inclusion of patient perspectives. Further, even when social services, public health, and health care organizations collaborate, differences in resources and power structures can lead one sector — typically health care — to dictate priorities and resource allocation.

The Robert Wood Johnson Foundation and its partners developed the Cross-Sector Alignment Theory of Change to help conceptualize and implement alignment at the systems level. The theory of change rests on four core components — shared purpose, governance, data, and financing — to guide cross-sector alignment. The theory of change guided the research of the first 10 rapid-cycle research grants awarded by the project. This chapter shares results from the first six of these projects, awarded between September 2019 and February 2020. Each focused on a different aspect of the theory of change and contributed to the collective learning about aligning.

OPERATIONALIZING CORE COMPONENTS AND EQUITY FROM THE CROSS-SECTOR ALIGNMENT THEORY OF CHANGE



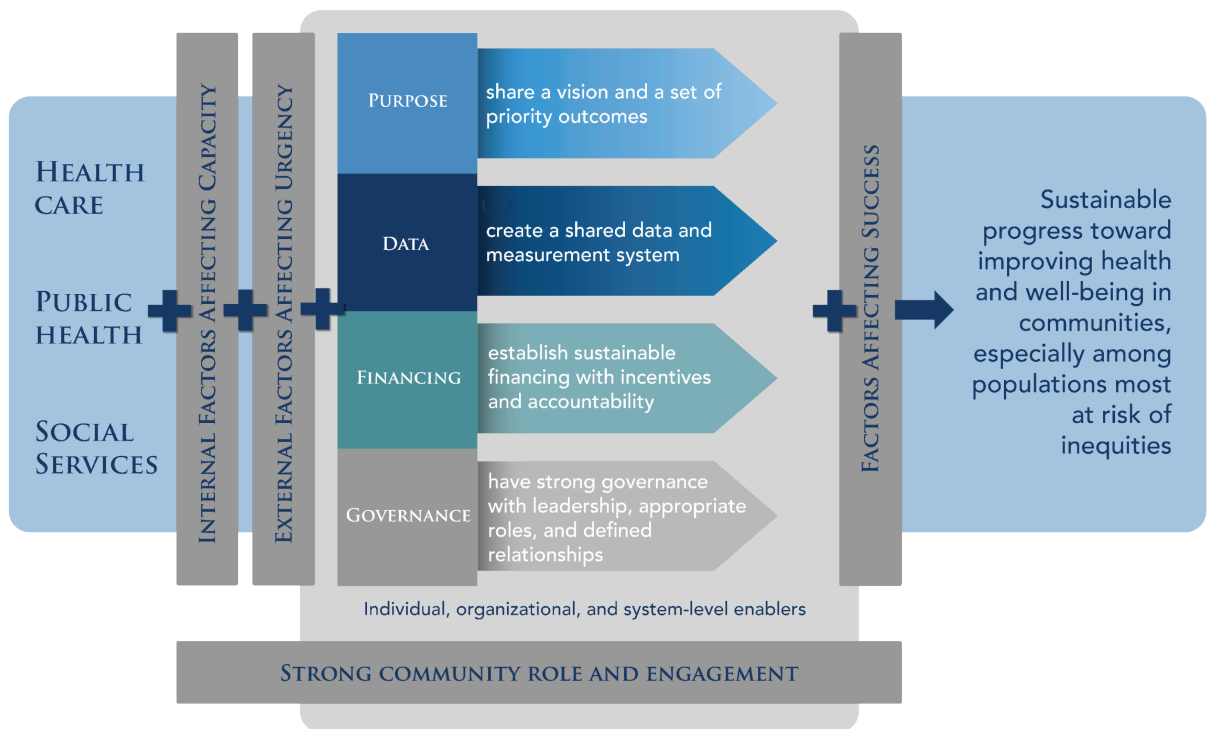


Jeremy Cantor
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Over the past decade, multisector collaboratives (MSCs) have become an increasingly popular way to improve community health.^{1,2,3,4} Rather than approaching issues on their own, in MSCs, organizations coordinate their commitment, resources, and action to create more effective solutions to community health problems.^{5,6}

Many MSC health initiatives describe a set of components, elements, or pillars required for an effective collaborative.^{7,8,9} As Figure 1 shows, the Robert Wood Johnson Foundation describes the complex process of developing an MSC in its Cross-Sector Alignment Theory of Change model. This model identifies four core MSC components: shared purpose, data, financing, and governance.¹⁰ However, while there is agreement on the necessary components, there is little clarity about how MSCs should develop and operationalize these areas.¹¹ To build out each of these four core components — and ultimately succeed in alignment — initiatives need clear guidance, concrete examples, and defined strategies.

Figure 1. The Cross-Sector Alignment Theory of Change¹²



In fall 2019, JSI partnered with the Georgia Health Policy Center (GHPC) to explore two primary questions that would better illuminate how MSCs are developing the four core components:

1. How are MSCs sequencing attention to and operationalizing the core components?
2. How have questions of equity emerged and been addressed over the course of component development?

To examine these research questions, our research team partnered with three MSC initiatives working at sites across the country:

- Way to Wellville (<https://www.wellville.net>);
- California Accountable Communities for Health Initiative (CACHI) (<https://cachi.org>); and
- BUILD Health Challenge (<https://buildhealthchallenge.org>).

We chose these initiatives because they were diverse in their geography, funding sources, and programmatic models.

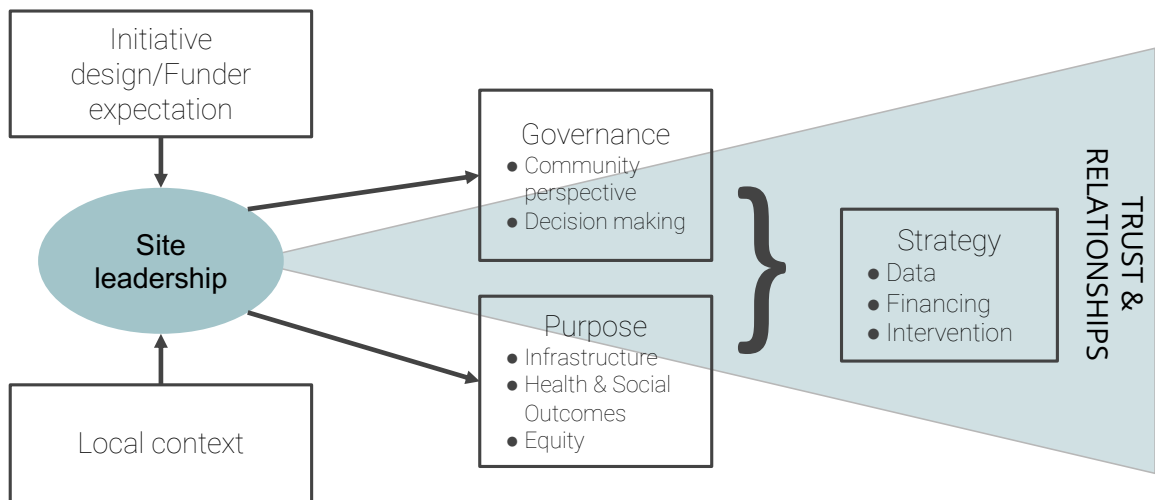
METHODS

Our research team used a mixed-methods approach to answer the research questions. We conducted a literature scan, qualitative interviews, and a document review, and then synthesized our findings, which we present below. To identify relevant literature to inform our qualitative interview guide, we scanned white and grey literature using academic search engines and an annotated bibliography that GHPC developed for the Aligning Systems for Health initiative. We then reviewed 30 articles using an extraction matrix and chose 12 for full review by all of our researchers. After reviewing the literature, we conducted interviews with three stakeholders — an initiative lead, site lead, and one additional stakeholder — at each of the three partner initiatives, for a total of nine interviews. The interviewed individuals also shared relevant initiative planning and monitoring documents, which we coded using an extraction matrix.

FINDINGS

During this inquiry process, several concepts emerged that were consistently reflected by both practitioners and researchers. Figure 2 shows these key concepts, which we outline below.

Figure 2. Key Findings Diagram



Purpose and Governance: Building Blocks of a Strong Foundation

Across initiatives and in the literature, *purpose* and *governance* emerged as initial core components for MSCs to develop and operationalize.¹³ Purpose and governance are described as a necessary foundation on which to build, and their development is viewed as taking a significant investment of time and resources.

It's about governance and a shared purpose and vision. Those two things are really foundational. — Initiative leader

Purpose — which is frequently used alongside the term *vision* — appears throughout initiative documents and stakeholder conversations.^{9,14,15} These sources describe purpose as

being defined early and developed concurrently with governance. Crafting a clear and resonant purpose requires an understanding of audiences, issues to be addressed, solutions to be applied, and potential outcomes and benefits. Further, considering the outcomes and benefits can help align the purpose with the interests of potential contributors and funders.

Sometimes we think we've created a shared vision, but it's only a shared vision of our friends and colleagues, so it's not truly a shared vision. — Site leader

To ensure that the MSC's purpose reflects community priorities as well, community members should participate in its development. Several collaborative representatives said their purpose altered over time due to shifting local conditions and changing priorities among key stakeholders.

The *governance* development process is consistently described as challenging and time-consuming. However, the payoff is large. Investing in relationship building; in assembling a diverse, representative set of stakeholders; and in level-setting between cross-sector partners is closely linked to long-term success.

Governance is what makes this happen. Governance is the reflection of having built trust and relationships. None of this works unless you have trust and relationships. — Initiative leader

Strong governance iterates and aligns the core components over time. It also reflects a collaborative's position relative to power and equity within the community (e.g., which institutions control decision-making and how resources will be allocated). Formalizing community representation in governance structures is another consistent theme, and collaboratives noted that the time required to develop effective governance structures is a point of potential tension with funders, particularly those attuned to outcomes-based timelines.

Data and Financing: Timing and Context Are Critical

Data was described as one of the most difficult core components to develop. Data issues

arise when resources are limited or unavailable, and when the data's ultimate use is unclear. One of the few sites that was able to successfully collect, analyze, and use data relied on a leadership team member's pre-existing data capacity, which included expertise and infrastructure.

The data infrastructure has just been very, very challenging. I think that's true across the board in our communities and in other multisector initiatives. — Initiative leader

In some cases, the drive to develop data systems comes from initiative funders more than from local stakeholders. Tension can also arise between using existing data, which is available and provides a baseline, and collecting original data, which is expensive but may better reflect the targeted outcomes and populations. Given the data capacity challenges and the need to align data strategy with goals and intervention strategy, it makes sense to focus on data later in collaborative development.

Similar to data systems, *financing* was described as challenging, as dependent on other collaborative development components, and as requiring specialized capacity. The literature, initiative documents, and interviews all indicate a need for MSCs to demonstrate new ways of using resources.^{15,16,17,18} We also found numerous references to treating health as a community good, clarifying value propositions, and approaching community health like a startup accelerator would¹⁹. All three initiatives expected their grantees to develop strategies for funding activities beyond the initial grant periods. We found frequent references to various financing tools and approaches, including braiding and blending funds and developing wellness funds.^{7,20,21}

However, we found no clear or replicable financial models or business plans; this makes sense, given that MSCs vary greatly and must respond to their local funding landscape. Collaboratives will likely produce more guidance on financing strategies as they mature.

Equity: Everywhere in Theory, Challenging in Practice

All three initiatives referred to equity as a “cross-cutting” principle that influenced development of all four core components — yet only one initiative had taken clear steps to

operationalize equity across sites. Several years into its work, and at the urging of one of its sites, this initiative’s leadership convened with funders and decided to dedicate technical assistance and specific funds to infusing equity throughout site processes.

We saw in hindsight that we really had to be more intentional. [Initially], equity was baked into the broader TA [technical assistance], but it wasn’t its own call-out or something we prioritized. [Later], we were able to get funding directed towards specialized technical assistance on health equity. — Initiative leader

The site had taken steps to embed equity into all of its processes using the funds secured by the initiative. It also hired an external racial equity facilitator to help its stakeholders discuss the community’s history of racism, identify power imbalances, and construct a plan for putting equity into practice.

The initiatives’ efforts and the practices documented in the literature reflect two primary issues in relation to equity: a lack of clarity about its definition and uncertainty about how to operationalize it. Terms such as *equity*, *disparities*, *social determinants of health*, *social needs*, and *community conditions* are often used somewhat interchangeably in the field. There does not seem to be a consistent approach or set of practices for establishing a shared root-cause analysis that connects current health priorities with historic and structural issues — particularly racism and discrimination.

Equity came through conversations of: “Here’s what we have,” and [asking] the question, “Why is a neighborhood like this?” When you really look at the challenges that they’re facing, it’s systemic exclusionary practices that created this. So you can’t not look at equity. — Site leader

While all of the initiatives are taking steps to bring an equity lens to their work, there is not clarity about the precise steps to take to comprehensively embed equity into developing the four components. When discussing how to operationalize equity work, focus is largely on community partnerships and “meaningful” resident participation in decision-making. Sites have also worked

to identify equity indicators and outcomes as part of their data and evaluation practice, facilitated discussion of historic racism and power imbalances, and tried to cultivate funders who understand and encourage equity work.^{22,23} However, we found little consensus in our literature review and interviews as to which strategies or tactics are effective, and everyone seemed to be actively re-examining their equity approach.

Leadership Capacity: A Key Ingredient from the Outset

Beyond the four defined core components, leadership capacity also emerged as important. Site leadership sits at an MSC's fulcrum. Impactful site leadership demonstrates the ability to reconcile initiative design, funder wishes, and local context in developing and operationalizing an MSC's core components. Rather than using a playbook or a clear set of guidelines to achieve this difficult balance, leaders typically relied on an inherent or cultivated set of abilities and practices.

While these specific attributes and skills are not identified in the materials we reviewed, impactful site leaders seem to have a mix of community organizing skills and entrepreneurial spirit. That is, they have on-the-ground organizing experience and a keen sense for cultivating financial partnerships.

People stay engaged because they know we are sincerely trying to work with them, and not for them. — Site leader

Effective leaders also appear to understand where gaps exist in their skill sets, and they are comfortable delegating some tasks — such as facilitating difficult power-sharing conversations or pitching to a specific potential funder — to others in leadership.

Trust and Relationships: Underlying Indicators of Success

During interviews, the concept of equity often emerged while discussing trust and relationship building. Sites and initiatives reported that building trust and relationships is central to their development. This is especially clear when developing governance and purpose. As we

described above, developing these two core components is slow, difficult, and important work — largely because of the necessity to build relationships and trust. Indeed, interviewees indicated that increased trust should be the primary outcome of the collaborative formation stage (in which governance structures and purpose are developed).

The one thing I do know is universal is you have to allow trust building to happen and have enough time for that to happen. It’s an ongoing thing, so you have to have strategies to keep that ongoing connection with your residents so people will keep showing up. — Site leader

Strong relationships are not formed overnight, particularly in communities with long-standing power imbalances. Relationships hinge on trust, and some communities have a history of distrusting the institutions and individuals engaged in MSC health initiatives. For this reason, MSCs should expect to spend time and energy not only establishing trust and building relationships with communities, but also re-establishing trust and repairing existing relationships. Trust and relationships therefore can be considered another dimension of MSC development that, when properly attended to, can appear early and grow over time to inform all other aspects of the collaborative.

Bringing partners together in this collaborative is not just a means to an end, but an end itself. — Initiative leader

DISCUSSION

The findings we outlined above have specific implications for effective, equity-focused cross-sector alignment. As we now describe, various cross-cutting themes and areas of tension and uncertainty also emerged during our research process.

Prescriptiveness vs. Flexibility

One central tension is how prescriptive initiatives should be regarding the model — or

development framework — that they expect sites to execute. There are a range of benefits and drawbacks to consider along the continuum from prescriptive (initiative-directed) to flexible (locally determined):

- *Prescriptiveness* generally allows for testing and replication of a well-defined model and gives local site leaders clear guidance and expectations.
- *Flexibility* supports tailored strategies to achieve high-level objectives given local context; it also allows for quicker initiative startup.

All three initiatives had elements of prescriptiveness and flexibility in their designs. Decisions about prescriptiveness and flexibility are necessary across all four core elements in the theory of change. For example, some initiatives require that sites:

- Select a focal health condition at formation (purpose);
- Have specific sectors or institutions on their leadership teams (governance);
- Secure local match funding (financing); and
- Monitor progress on a small set of metrics (data).

Initiatives also provided a range of guidance, from detailed annual milestones to a high-level set of principles.^{24, 24}

These efforts involve considerable nuance — even around issues that seem simple on the surface. For example, it makes sense that local sites want as much initial funding as possible. However, a few sites noted that initial funding can create counterproductive power dynamics and barriers to distributed leadership. Alternatively, one initiative requires funding to be held by a community-based organization, not a health care or governmental entity, as a way to use prescriptiveness to counter existing power dynamics.

There is no definitive answer or clear guidance about how prescriptive an initiative should be or where flexibility is most important; it depends on the intentions and objectives of the initiative leaders and funders, and how disparate the contexts are at local sites.

At the end of the day, people don't care about the models, they care about the results. — Initiative leader

Accommodating Interconnection and Iteration

Throughout our research, we consistently saw and heard that the MSC development components are *interconnected* and require frequent iteration. In this context, interconnected refers to the fact that each component must be developed in relationship with the others. For example, the financing approach has implications for governance (as potential contributors may want decision-making authority) and vice versa (as procedures for resource governance should be clearly described). Those interconnections will likely vary over time as changes to one component require revisiting and altering the others. This iteration process takes time and effort to ensure that it is systematic and includes key stakeholder input. Indeed, all of the initiatives we studied described the formative stages as taking longer than expected, with timelines shifting to accommodate relationship building and iteration. When funders, partners, and leaders understand and accept this baseline reality of collaborative development, MSCs will be able to set more realistic expectations and, ultimately, to realize more success.

Public health change is a long-term game. Generational change is not something we can do in a couple of years. — Site leader

The notion of *iteration* is very hard to capture in two-dimensional models. In addressing the challenge of representing and understanding a dynamic, iterative process, we frequently encountered use of metaphors, both to help reassure initiative and site leaders that there is some order in the apparent chaos, and to share the MSC notion with broader audiences. We heard MSC development described in many ways, including building the plane while flying it, *building the bridge while driving on it*, *a spiral moving forward*, and *a hot restaurant kitchen with multiple dishes being cooked at the same time*.

There is a lot of iteration that happens in all the communities. ... None of this happens where “We got that checked off, we are done, we got it, we’re golden.” Almost every one of the [sites] has revisited their vision, almost all have revisited their purpose and have revisited their governance. — Initiative leader

One metaphor that resonates with us is the process of *building a house*. The house construction metaphor can help to explain the interconnections between the different core components, as well as how the process of developing one component informs and impacts the others. As Figure 3 shows, the metaphor includes elements such as:

- The architect (initiative leader/funder),
- Contractor (local leaders), and
- Utilities (equity running throughout, providing power, supporting basic well-being).

The illustration has limitations, however. As with any two-dimensional attempt to capture real-world phenomena, questions arise about what is missing. Still, we include it here to stimulate thought about the potential value of interconnection metaphors for MSC development.

Figure 3. House Building as a Metaphor for MSC Development

Architect: the architect is the initiative that provides the materials and blueprint for building the house.

Contractor: the contractor is the local leadership in charge of implementing the vision for the house and leading the building process.

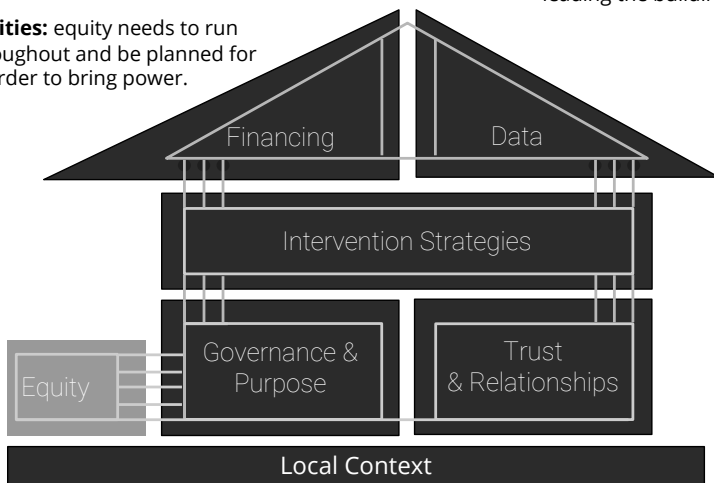
Utilities: equity needs to run throughout and be planned for in order to bring power.

Roof: the roof of data and financing are built after the rest of the house. Data and financing contribute to making the house sustainable.

Living area: Intervention strategies are the living area, requiring constant attention and iteration, and building upon the foundation of governance, purpose, trust, and relationships.

Foundation: the house must be built upon a solid foundation of governance, purpose, trust, and relationships.

Ground: local context is the ground being built on and is essential for the contractor to understand.



Bringing Racism into Focus

For MSCs, bringing historic and structural racism into focus is both difficult and essential work. A central challenge for these collaboratives is to improve the health of a broad and often diverse community that has a health status rooted in historical decisions and actions that have created the community as it exists today.

Part of the equity training [was looking] at the history of these neighborhoods. ... We were in the room with residents who are living in the residue of redlining. We were sitting there with a health system partner who excluded African Americans from their hospital and people old enough to have experienced that exclusion. It did something for the respect between the residents and the partners to sit in all of that, have productive conversations. — Site leader

Without talking about equity and explicitly acknowledging power and privilege, collaboratives can reinforce the status quo. And in most U.S. communities, that status quo is built on and reinforces a history of structural and institutional racism. Conversations around racism, power, and privilege are daunting; one site talked about some stakeholders wanting to focus on “economic mobility” rather than “racial equity” in order to avoid pushback. However, sites did say that progress is possible through skilled facilitation and the use of data to connect the dots between existing disparities and discriminatory practices and policies. These conversations must be grounded in the collaborative vision, and they require introspection and true power sharing.

We found that the collaboratives were wrestling with how best to approach the intentional work to discuss and dismantle racial inequities and other systems of power. A lack of careful focus can lead to a lack of shared root-cause analysis among partners. For example, tension can arise if one partner describes the equity work as providing culturally competent care, while another describes it as working to address structural racism in housing policy. Such tensions are especially likely if individuals with different institutional power and resource control — such as a local hospital leader and a community resident — see the equity issue differently.

Working on racism, power imbalances, and policy and structural issues is long-term, intensive work that is often at odds with the timelines and impact expectations of most initiative designers and funders. Further, making such work a focus can delay development of the core components, particularly sustainable financing and evidence of impact. The collaboratives that have shown leadership in managing these issues have explicitly examined power and what it means to work with the community and “do equity work;” they have also identified significant resources to support their efforts.

CONCLUSION

This inquiry into MSC development yielded rich findings that have implications for the field, and it also highlighted areas in need of additional research. We found that most sites begin by developing purpose and governance — time-consuming processes that set the foundation for developing other collaborative components. Site leadership and initiative prescriptiveness influence how MSCs approach core component development and have direct implications for the development of trust and relationships. Although sites and initiatives indicated a commitment to equity, there is a need to operationalize it formally and intentionally within the MSC development process.

Future studies should investigate effective equity practices that MSCs use at both the initiative and site levels. Also, it will be important to look more closely at the role of leadership in site-level success. Enumerating local leadership characteristics at more advanced sites will help the field develop strategies aimed at building local leadership capacity. Additionally, policy levers at a local, state, and federal level would enable development of each of the collaborative elements. Although investigating existing and potential policy solutions is critical work, it is beyond the scope of this inquiry. Finally, more case studies, allegories, and metaphors are needed to help illustrate the iterative, constructive nature of this work.

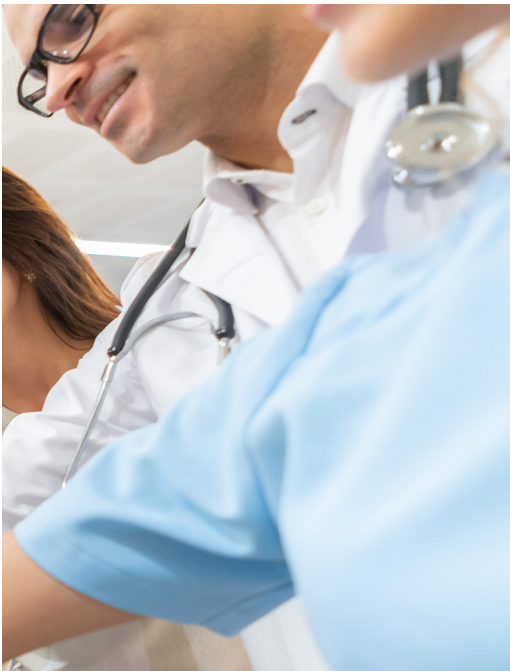
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TESTING THE THEORY OF CHANGE: LESSONS FROM HOSPITAL-EMBEDDED SOCIAL SERVICES IN THE SPRING 2020 COVID-19 CRISIS





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Safety net hospitals are often the last recourse of low-income people dealing with poor health, yet because such hospitals focus on clinical treatment, they lack resources to address the social determinants of health (SDoH). In this chapter, we investigate the Cross-Sector Alignment Theory of Change’s potential value in the context of projects in which community-based organization (CBO) staff members are embedded in hospital settings to increase access to existing services that address SDoH needs outside the hospital walls. Specifically, we explore whether implementation practices informed by the theory of change can lead to improvement in the quality of social services referrals — as well as in referral follow-up and completion — in clinical settings during a global public health crisis.

BACKGROUND

In 2018, Public Health Solutions (PHS), New York City’s largest public health nonprofit, was selected as a bridge partner to support the Hospital-Community Partnership Initiative. This initiative was launched by OneCity Health, a performing provider system set up by NYC Health + Hospitals (H+H), the country’s largest municipal health care system. OneCity Health was one of many new health care networks supported by New York state’s 1115 Medicaid Waiver Delivery System Reform Incentive Payment (DSRIP) program. OneCity’s Hospital-Community Partnership Initiative was a multistakeholder collaborative effort to initiate or revitalize connections with community resources to contribute to the DSRIP’s goal of achieving a 15% reduction in avoidable hospital costs over five years.

The initiative had a shared purpose, agreed-upon metrics, financial support, and borough-level governance bodies with representation from H+H, OneCity Health, PHS, and CBOs. As the bridge partner, PHS received funding to codesign and implement demonstration projects in four boroughs, each of which chose a colocation intervention model in which CBO employees were located at the hospital sites. The model was rolled out in multiple hospital facilities in August-September 2019. Although there were variations at the three participating hospital sites (see Table 1), the initiative’s workflows followed the same path across sites: clinical teams (social workers, nurses, or accountable care managers) identified patients meeting predetermined criteria (such as being high utilizers of emergency departments) and referred them to CBO staff. These

staff members met the patients at bedside or contacted them by phone if they had already been discharged. CBO staff confirmed the patients' needs and verified eligibility for services. If eligible and interested, patients were enrolled in services and received a range of support for several weeks. Enrollment options included social services, support in connecting with a primary care provider, and home visits. The projects envisioned CBO staff members acting as a one-stop shop for a broad range of community-based services and resources, with two overarching goals: to avoid multiple uncoordinated referrals to organizations that duplicate services and to ensure effective follow-up.

Table 1. Summary of Characteristics for Each Site

| CHARACTERISTIC | SITE A | SITE B | SITE C |
|------------------------------|---|---|---|
| Implementation of colocation | On-site, embedded within one clinic | On-site, close to social workers near emergency department | On-site, in an office serving three clinics |
| Summary eligibility criteria | <p>Patients with multiple comorbidity</p> <p>Exclude patients with dementia due to complexity</p> | <p>Exclude some diagnoses (e.g., asthma, substance abuse, and dementia) due to complexity or because they are already being served by other initiatives</p> | <p>Patients with multiple comorbidity</p> <p>65 years old and above</p> <p>Exclude dementia due to complexity</p> <p>Specific ZIP codes</p> |
| Referral process | Decided collectively during morning team huddles | Social workers discuss referrals with CBO and introduce patients to CBO staff | Clinical staff assess patients using a checklist and provide patient names to CBO staff |

As with all colocation models, the quantity and quality of referrals made to CBO partners were critical to the project's success: If referrals were scant or ineligible, patients would miss the

opportunity to get assistance, and resources would not be optimally deployed. Our study's goal was thus to elicit a better understanding of the referral process and workflow; we also sought to understand what makes referrals successful from multiple perspectives (the patient, the clinical staff, and the CBO staff). We then mapped these understandings to the theory of change and used this to inform project changes.

In spring 2020, however, the COVID-19 pandemic onset in New York City forced us to reconsider our plan. In early March, public hospitals were inundated — initially by demands for COVID-19 tests, and then by sick and extremely sick patients — and physical distancing measures to slow contagion were rapidly implemented. The consequences for vulnerable patients, as well as for the health care system and the CBOs they depend on, were profound.

These consequences included:

- Vulnerable patients were immediately isolated, with medical appointments and procedures postponed, home visits canceled, and so on.
- An immense burden on public hospitals' clinical teams, who had to prioritize patients suspected or confirmed to have the novel coronavirus while managing their own safety.
- An acute strain on CBOs, including the need to set up work from home; adjust revenue, often including staff furloughs and downsizing; invent new strategies, including telehealth visits and remote performance monitoring; and protect their employees.

In relation to our project, the pandemic required a pivot by the hospital-embedded social programs. Following a four-week transition period to refocus priorities and workflows and develop new scripts, PHS, H+H's Office of Population Health, and OneCity Health deployed the CBO teams to call all of the discharged patients on the lists provided by H+H Office of Population Health, assess their needs across a range of SDoH, and refer them to appropriate resources.⁷

METHOD

Although the COVID-19 pandemic altered our original plan, we were able to compare the number, quality, and successful completion of referrals before the pandemic emerged in New York City (September 2019-February 2020) as well as during its peak in April-May 2020. For this study, we define:

- The number of referrals as the number of patients referred by the health system to the CBO;
- A quality referral as a referral that meets all eligibility criteria and none of the exclusion criteria (which varied for each project); and
- *Success* as a referral resulting in the patient enrolling in the targeted service.

We collected information at each hospital site before the COVID-19 crisis, when CBO staff members were colocated on site and working with clinical teams, and during the COVID-19 crisis, when new workflows were established and clinical teams were removed from the referral process.

Two qualitative studies illuminated the results. In the first study, a team of qualitative research consultants conducted a series of semistructured interviews using the critical incident technique, in which a real event — in this case, the fact of being referred or making or receiving a referral — is recounted and then used to discuss how typical or unusual it may be.^{8,9} Beginning on February 1, 2020, we invited all patients enrolled by CBO staff to participate in the study and provide their perspective on the critical incident. If they agreed, they signed a consent form and let us share their phone number with the research consultant. As an incentive, participants received a preloaded \$60 Visa card once they completed the interview. After completing a patient interview, the consultant reached out to the CBO and clinical staff members involved in the patient’s referral and interviewed each of them. In this way, our plan was to triangulate interviews from “triads” comprising patient, CBO staff, and clinical staff. The initial questions were anchored on the particular patient and then were expanded to ask about the referral’s success level and how typical it was compared to other referrals. The aim of the interviews was to elicit information about the determinants of quality referrals from various perspectives, identify concordant and discordant perceptions of the referral experience, and map the findings to the theory of change.

In the second study, which followed the program’s COVID-19 pivot, the consultant interviewed administrative staff involved in workforce redeployment at H+H Population Health and OneCity Health, and again mapped the findings to the theory of change.

FINDINGS

Our qualitative results highlight the importance of highly collaborative approaches in designing and implementing a referral workflow, with clearly established roles between CBO and clinical staff.

Qualitative Interview Results (Pre–COVID-19)

In the first (pre–COVID-19) study, two qualitative research consultants conducted six interviews with patients, three in English and three in Spanish. The interviewees — five women and one man — had an average age of 74, and an age range of 70-83 years old. Following these interviews, the consultants interviewed all CBO staff members who worked with the patients. For four of the six patients, they also interviewed the clinical staff members who had initiated the referrals; the remaining two interviews were being scheduled as the pandemic started, and the clinical staff members were unable to fulfill the requests. During the second study, the research consultants conducted four more interviews: two with hospital administrators, and two with additional CBO staff. We completed a total of 18 interviews.

Definition of Success

All stakeholders were aligned in how they defined success: as increasing patient access to a *range of services outside the hospital walls*, with the goal of reducing hospital readmission and emergency department visits. And, indeed, the patients said they had received a diversity of services, from translation to prescription refills, home-delivered meals, transportation support, and help with scheduling medical appointments. Patients overwhelmingly praised the support the CBO provided and were generally satisfied with the hospital as well. CBO staff saw success specifically as being able to enroll a patient and then assist the patient with services. Hospital staff saw success as “influencing a patient so that they would accept the referral recommendation.”

Factors Contributing to or Impeding Success

The CBO staff members described the referral process in detail for each hospital facility, or site. At Site A, CBO staff discussed referrals during a daily interdisciplinary round at a specific clinic. At Site B, social workers were the primary source of referrals to CBO staff for high-need

emergency department patients. At Site C, clinical staff identified patients that met the criteria using a checklist across multiple clinics. They then offered the services to patients and, assuming the patients agreed, contacted the CBO by phone or email to make the referrals. The interviewed patients appeared to have no awareness of how, why, or by whom they had been referred to the CBO. In that sense, the referral process was not just seamless, but essentially invisible to patients at all three sites.

Staff at sites A and B emphasized the integrated, collaborative approach as a success factor:

OK, so usually how it works is we receive referrals during the interdisciplinary huddles ... and then all three teams can decide if a referral could be appropriate for us. ... They're really — the providers, the medical providers, attendants, residents — they're really open to our program. — CBO staff member (Site A)

I have worked very close with the social workers, and I think they have made it as smooth as possible for me and taking care of the patients in the community. — CBO staff member (Site B)

CBO staff members were eager to receive referrals and to continue the conversation with patients to encourage service enrollment. The greatest difficulty these staff members identified in relation to referrals was having to triage and turn down ineligible patients.

At Site C, which used an eligibility checklist, clinical staff had to identify patients that met the criteria, assess their readiness, resolve their ambivalence, and motivate both the patients and their caregivers to act on the referral. This process was perceived as labor intensive:

We base it on a problem list, so it's not just asking everyone. ... The patient has to be 65-years-and-plus and have some condition — might be hypertension, diabetes, chronic heart failure, things like that. We do cover four ZIP codes ... but if they look elderly and it looks like there's a family member with them, I'll go introduce myself. — Clinical staff member (Site C)

I think that at least 80% of the referrals that we have given to [CBO] is because of just selling it to people. — Clinical staff member (Site C)

Design and Implementation Factors: Eligibility Criteria, Coordination, Role

Interviewees at sites B and C said that needing to verify patient eligibility criteria for the program was an impediment and cited the relatively arbitrary nature of those criteria (ZIP code, age, disease status) for a service aimed at addressing the SDoH. Although our projects aimed to fill gaps in services, segregating patients based on eligibility criteria created challenges in the fast-paced hospital environment. At Site B, substance users were excluded from program participation due to the expertise required to deal with these patients — even though doing so had been identified as a site priority.

Well, sometimes I get a referral and the patient is not actually eligible. ... I would say a great portion of the patients that come to the emergency room [are not eligible]. — CBO staff member (Site B)

They [the CBO staff] only serve some ZIP codes and patients come from all over. Also, they don't speak Russian. It's a Russian population. — Clinical staff member (Site C)

Qualitative Staff Interview Results

Our qualitative interviews with CBO staff and hospital systems administrative staff during the COVID-19 crisis reinforce the importance of a close collaboration when making workflow decisions, but this time collaboration was centralized with the administrative team as a way to remove the burden from the clinical teams. This suggests that facilitating multilevel collaborations can help sustain alignment activities during a health crisis.

Definition of Success

All interviewees viewed as successful both their connections with patients during a time of isolation and crisis and their ability to refer them to urgently needed resources — especially food. When the COVID-19 crisis began, we experienced a four-week program gap while we redesigned the project to address the changing situation and the CBO staff adjusted to working remotely; still, all interviewees emphasized that the transition was rapid given the scale of the project's redesign. Not only did we have to identify new resources, but we also had to develop new workflows, create

guides, and train staff.

Tragedy struck, but we were able to really quickly say, 'OK. If it's not the [emergency department] patient, then it's the COVID-19 patient.' — CBO staff member

I feel like we definitely did respond appropriately, as quickly as we could. — CBO staff member

And so I felt like, 'Oh my god, we need to do this. We need to do this. Like people need stuff.' But I guess unfortunately the reality is it takes time to pull these pieces together. So I guess in terms of like normal time, like developing a program ... we pulled this together very quickly. — H+H staff member

And so it was really seamless — more seamless than you would think considering we threw together this project in like a week or two and [have] outreached over 10,000 patients now. — H+H staff member

Factors Contributing to or Impeding Success

The hospital team stepped up to create outreach call lists, make them available to CBO teams through a secure system, and coordinate redesigned activities. Crucially, the team fast-tracked CBO staff member training so they could serve as trusted enrollers in New York City's COVID-19 emergency food delivery program, GetFoodNYC, which enabled them to directly enroll food-insecure patients. CBO teams redirected staff time to this effort. A weekly meeting with hospital and CBO staff facilitated decision-making about priorities, information sharing, and troubleshooting. Clinical teams were intentionally removed from that effort so they could prioritize medical treatment, and CBO teams conducted all of the outreach.

With resources coordinated and dedicated to a single approach, issues of duplication were virtually eliminated. At the same time, interviewees pointed out that the existing relationship between the CBO and each hospital probably helped win trust from patients. Further, one facility asked its CBO team to also reach out to the families of hospitalized patients to help alleviate the anxiety of not being able to visit their loved ones.

We found relatively few comments about implementation barriers or factors that impeded

success. One factor that was mentioned was the need to support and protect the emotional well-being of CBO team members, who were making often-difficult calls during the peak of the crisis; interviewees also said it was difficult to provide certain needed services — such as follow-up medical appointments and home-delivered prescription drugs — to patients during that time.

I think it [worked] because the hospital and CBO partners built strong relationships while the partners were on site. And they saw the value of this program. — H+H staff member

What was in place with this program that sort of kept it going? I think it starts with leadership, and having a social worker. ... I think we recognized what we needed to do. — CBO staff member

It fit in extremely well. ... There was like a group of like eight or 10 of us [bridge partner, CBO, and hospital staff] at any point that were like in a leadership supervisory capacity shaping the work. ... This kind of crisis, I don't think any of us have been through a time like this in our lives. Sometimes when you start a project, the group you're working with, you all have to get aligned. And with this group, it was just like, 'Yes. Like, this is it. We need to do this.' Like, we're all on the same page. — H+H staff member

And there were a few different teams that participated in this work, but I felt like we all just worked really well together. — H+H staff member

Quantitative Analysis Results

Before COVID-19, Site A had a robust flow of referrals—on average, 37 per month, compared to 27 and 28 per month at sites B and C, respectively. As Figure 1 shows, almost all of Site A's referrals were eligible (92%), and it had a high enrollment rate (82% of those eligible), making it the most successful site overall. During COVID-19's early peak, the site managed a large influx of referrals and enrolled an average of 26 patients per month in April and May, which represents 19% of those referred via the list (see Figure 2). Site B had the lowest rates of eligibility (70%) and enrollment (32% of those eligible) before COVID-19, but adapted well during the surge and enrolled 25% of those on the list (13 people monthly). Site C also had relatively low

referral eligibility before the COVID-19 pandemic (75%), which is particularly low given that the patients had been prescreened for eligibility. However, Site C enrolled 57% of those who were eligible, which was a higher rate than Site B's, but still well below Site A's performance. Site C also appeared to face disproportionate difficulties in reaching and enrolling patients during the COVID-19 peak, with only 12% of patients on the list enrolling.

Figure 1. Referrals and Enrollments Before COVID-19

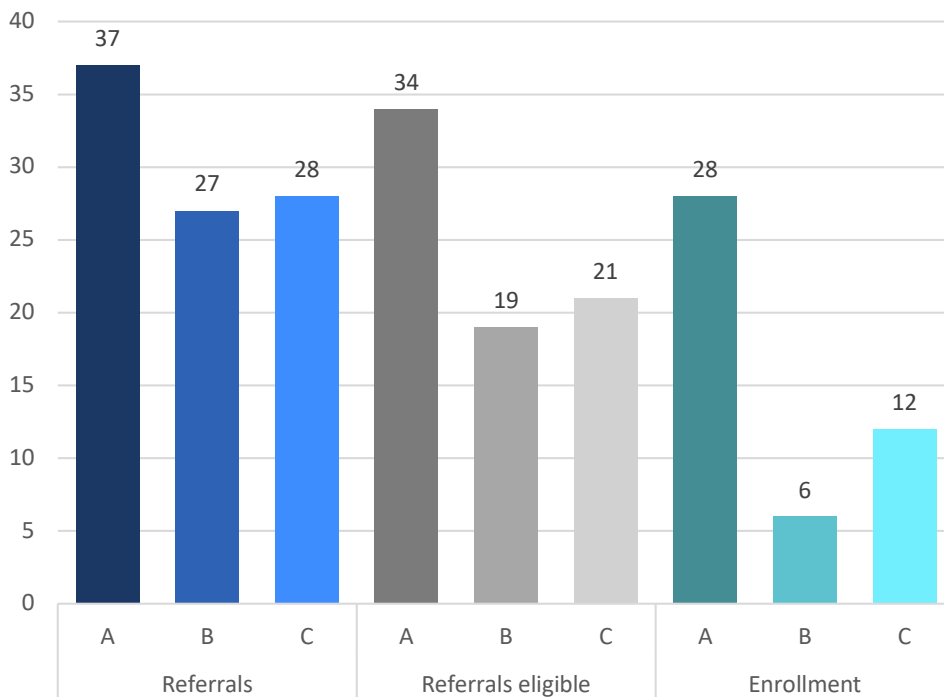
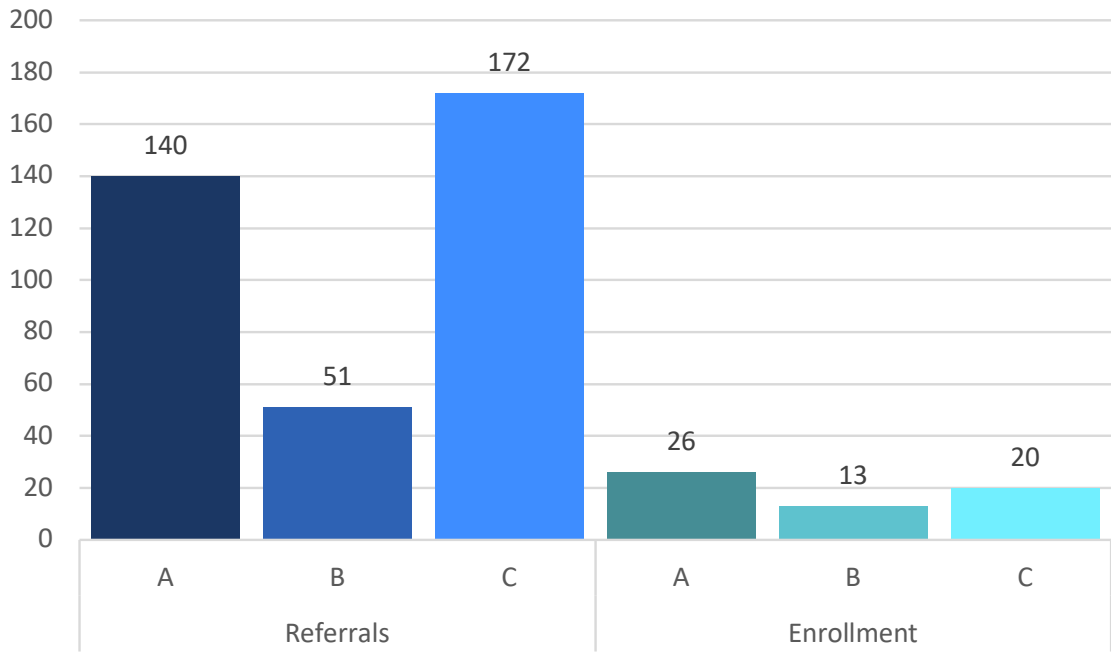


Figure 2. Referrals and Enrollments During COVID-19 Peak



Mapping the Findings to the Theory of Change

Table 2 shows the theory of change’s relevant core components and highlights the factors that were found to support or inhibit the project.

Table 2. Survey Findings Indicating Facilitators (+) and Barriers (-) Across Core Theory of Change Components Before and During COVID-19

| TOC COMPONENT | BEFORE COVID-19 | DURING COVID-19 PEAK |
|---------------|--|---|
| Purpose | <p>Improve health outcomes by addressing SDoH, connecting patients who have high acute-health care use and other risk factors to community services and following up with them for 30-90 days.</p> <p>Findings (+) Tightly defined setting (Site A) (-) Not clearly positioned compared to other initiatives (sites B and C)</p> | <p>Improve health outcomes by addressing SDoH, connecting every patient discharged from the hospital during the crisis, including recovering COVID-19 patients, to services they need immediately.</p> <p>Findings (all sites) (+) Straightforward objective (+) Centrally coordinated implementation</p> |
| Process | <p>Each hospital adopted different strategies to identify potential patients (such as using checklists or a collaborative approach).</p> <p>Findings (+) Collaborative approach (sites A and B) (+) Access to hospital resources such as social workers (sites A and B) (+) Quick intervention by CBO (sites A and C) (-) Checklist used to make the referrals (site C) (-) Complex eligibility criteria for accepting referrals (Site B) (-) Coordination with other services (Site B) (-) Changes in the site's available social services resources (sites B and C)</p> | <p>H+H administrative staff and CBO staff jointly developed project protocol and tools; one site (Site A) asked CBO team to conduct additional outreach work.</p> <p>Findings (all sites, unless specified) (+) Highly collaborative approach (+) Cross-sectoral leadership group with decision-making authority (+) Rapid pivot to meet specific needs expressed by the site (Site A) (+) Unique tools used across services (+) No overlap/duplication (+) Prior relationships between partners helps build trust with patients (-) Limited services available to patients (-) Some patients continued to face challenges in sharing personal information by phone</p> |
| Governance | <p>Clinical staff identifies potential patients, and CBO staff enrolls them in project.</p> <p>Finding (+) Concerted approach (Site A) (-) Decision to refer from a menu of options is made at the clinical level, not at the CBO level (Site C) (-) Decision to accept a referral at the CBO level is further limited by the need to verify eligibility for other initiatives (Site B) (+/-) Clinical team made judgment about potential candidates (Site C)</p> | <p>Administrative staff provides list of discharged patients.</p> <p>Finding (all sites) (+) Clearly defined roles</p> |

DISCUSSION

Despite their intertwined effect on people's lives, the public health, health care, and social services sectors play different roles and have different goals, making collaboration difficult. The focus on alignment across various domains in the theory of change provides an opportunity to resolve this challenge and to integrate diverse services to better meet patients' needs.

Testing the Theory of Change in a Dynamic Environment

Our study presents findings from projects that shared a general purpose, yet had various implementation approaches across multiple hospital and community settings that were significantly transformed by the COVID-19 pandemic. Our data found one high-performance site in terms of volume of patients both referred and enrolled, one with midlevel performance, and one with low performance. The high-performing site (Site A) appears to have benefited from formulating the project's purpose into a well-delineated, focused scope, which was then implemented in a collaborative manner. By contrast, the average-performing site (Site C) started with a much broader scope and was implemented using a checklist-based, step-by-step method. Interestingly, the third site (Site B) had both a broad scope and a collaborative approach, but faced tremendous challenges related to overlapping initiatives and complex eligibility criteria, which resulted in the lowest performance in terms of referral quality and enrollment.

When pivoting during the COVID-19 crisis, we observed that performance differences across sites were maintained — and attenuated. This suggests that the new project's narrow focus, combined with a highly coordinated approach led by a small group of hospital and CBO staff, was appropriate during the crisis, but also that successful existing CBO-hospital relationships translated into higher rates of enrollment during remote outreach. Further, the site that quickly took advantage of its existing collaboration with the CBO to meet an emerging unmet need — that of calling families — happens to have been the highest performing one. This is an important element to consider for sustainability.

Lessons Learned for Cross-Sector Alignment

Analyzing these differences using the theory of change's structured framework points to several lessons.

Establishing a common purpose is fundamental. Further, our experience suggests that a focused purpose may translate into a clear scope, better implementation processes, and fewer coordination issues. Such a focused purpose should precisely indicate the target population, how the initiative's purpose fits with similar or overlapping initiatives in each sector, and how critical those other initiatives are to each sector's mission. Such clarity will facilitate understanding of the program elements and enhance adoption. It's possible that Site C's checklist method was in fact a byproduct of the project's broad scope across multiple clinics, which the site needed to break down into a more manageable approach.

The need for appropriately defined roles also emerged as a key area in which varied definitions appeared connected with varied performance. Although roles were designed to be similar at all three sites, practical distinctions arose, including deciding and communicating who was responsible for explaining the project to a patient and facilitating enrollment, and who was responsible for assessing eligibility. At Site A, we learned that both roles were jointly fulfilled, a factor apparently facilitated by a solid understanding of the site's simple eligibility criteria. At Site B, the CBO team observed that part of its role was to decline patients who did not meet program requirements. This happened frequently, despite the team's strong working relationship with the clinical team. The issues here included that the criteria excluded too many patients and that the site had a patchwork of other social interventions occurring simultaneously. At Site C, clinical staff members verified eligibility and also saw themselves as salespeople — and thus as both gatekeepers and cheerleaders for the project. However, this dual role did not appear to be particularly acknowledged by the CBO staff. At all sites, the tools and processes reflected the various roles. Our findings suggest that defining staff roles that inculcate joint decision-making and collaboration across sectors yields greater success.

The transition following COVID-19's emergence had two consequences on role definition: it completely removed clinician teams from the workflow and greatly simplified the CBO team's role. Without the preliminary screen provided by clinical teams talking to patients and their

caregivers, the number of referrals increased, and the acceptance rate declined. So more referrals were made, but a smaller proportion enrolled, resulting in a similar number of patients served.

Outstanding Questions and Future Research

Our study did not examine the reasons why such a high share of patients (84%) turned down a program that provided social services during one of the worst health crises ever faced by New York City and the country as a whole. If clinical teams had talked to patients about the program and flagged those they deemed most in need, would this have created trust in the outreach efforts, and increased the number of people served? A parallel problem that we did not investigate raises equity concerns: Did the digital divide have an impact on access to social services via telephonic or virtual visits? Addressing these two outstanding questions is essential to improving outreach around SDoH services, which is especially critical in times of heightened need.

Our study did not aim to elicit information about the resilience of cross-sector alignment or to examine how the theory of change can inform better resilience; however, our findings do provide a few pointers here that should be further investigated. Defining resilience as “the system being able to adapt its functioning to absorb a shock and transform, if necessary, to recover from disaster,”¹⁰ we can conclude that clinical teams’ role in ensuring aligned systems is critical yet extremely fragile, as the shock understandably led to focusing all efforts on triaging and treating patients. What are strategies to strengthen screening for other needs and for patients of average risk level in times of crisis? Our findings also did not elicit comments regarding the financial structure of the projects, but they were all funded by the hospital’s performing provider system. While this contributed to a hospital-centric structure and decision-making process, it also ensured the hospital system’s continued participation in and commitment to the project. Future investigation of the drivers of hospital participation in cross-sector alignment is needed, as it ties in with questions of operational and financial sustainability. Cross-sectoral directorates and board composition might be an important component of this work. Another critical gap that warrants investigation is in systems that communicate and integrate information with electronic medical records and integrated electronic communications across the health care, public health, and social services systems. Finally, we highlighted the importance of collaborations both in terms of process and

in terms of role definition. Adopting a collaborative model aimed at going beyond the patient's medical needs demands a dedicated team culture, facilitation, and leadership.¹¹

CONCLUSION

The theory of change provides a useful framework for understanding different levels of performance between colocated social services in multiple hospital settings. Our study highlights the importance of a simplified, no-wrong-door approach for clinical teams to make referrals; it also found that a focused purpose implemented by collaborative teams might be more effective than broadly defined goals implemented iteratively by a single team. Although the COVID-19 pandemic in New York City severely disrupted cross-sector alignment projects and highlighted how fragile the links between health care, public health, and social services become in times of crisis, it also provided an opportunity to examine how rapidly reconfiguring the interface between health and social services during a crisis can ensure continuity and improve health and social outcomes.

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DATA SHARING IN CROSS-SECTOR COLLABORATIONS:
INSIGHTS FROM INTEGRATED DATA SYSTEMS





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Individuals and families facing unmet social needs such as housing, food security, and education are at a higher risk for adverse health outcomes¹. Given this, efforts to improve population health must extend beyond the medical care and public health sectors to address these needs and better coordinate efforts across the health and social service sectors.

Researchers have proposed *data sharing* as a key component of such cross-sector collaborations both to improve the health and well-being of people and communities and to address inequities². Several states use integrated data systems (IDS) to link administrative individual-level data across multiple health and human services to better understand and address a full range of their clients' health and social needs.³

To identify factors that facilitate cross-sector data sharing, we collected and analyzed data from publicly available sources, as well as from our interviews with national experts and stakeholders in two states with operational IDS. Among our key findings are that understanding privacy laws, leadership buy-in, and the type of organizational culture that values data are important conditions for data-sharing efforts. We also found that establishing legal frameworks and governance structures and promoting data literacy are promising strategies for fostering such conditions. Finally, we found that in data-sharing efforts, people skills are at least as important as technical skills — and that people and communities whose data are being collected and shared are often absent from discussions and decision-making about cross-sector data collaborations.

BACKGROUND

The Cross-Sector Alignment Theory of Change posits that when health care, public health, and social service systems align across four core enablers — shared purpose, data, financing, and governance — they can better work together to address inequities in community health and well-being.² To achieve this goal, however, such cross-sector efforts often face barriers, with data sharing identified as a top challenge. , To promote data sharing in cross-sector alignment efforts, we examined well-established IDS to learn about key data-sharing facilitators and barriers.

A primary objective of IDS is to link individual-level data across various public programs, thus providing a comprehensive picture of the interconnected needs of individuals across health, social services, and other sectors.^{6,7} IDS can improve decision-making in public administration and

policymaking by enabling various data analytics for program monitoring and evaluation, business operations, and case management. For example, IDS can be used in longitudinal, population-based research to examine service utilization, the risk and protective factors of program users, and utilization costs.^{6,8,9}

Prior research has found that effective IDS use is facilitated by establishing four key components: a governance structure, a legal framework, technology and security infrastructure, and data standards.^{10,11} A governance structure articulates the purpose and manages the policies, procedures, and technologies needed for data sharing and use. This IDS governance should include diverse stakeholders, including executive leaders, front-line workers, researchers and data analysts, program beneficiaries, and the public at-large.¹² Government data must be shared and used within the legal framework of various federal and state laws and regulations.⁹ To protect and secure data while records are being shared and analyzed, agencies must invest in appropriate technology and security infrastructure. Finally, data owners must define and agree on common data standards to ensure that they share reliable, quality data.¹²

Challenges to creating and using IDS include misunderstanding data confidentiality laws, public mistrust of government data collection, limited organizational resources, and the potential of IDS to perpetuate inequity. Inconsistencies among federal, state, and local laws and regulations that guide administrative data use, as well as variations in how public agencies interpret these guidelines, often result in a complex, time-consuming process of negotiating data-sharing agreements.^{9,12,13} Another challenge to data sharing is a lack of public trust in government, including suspicions about the government collecting personal data and fear of privacy breaches of protected personal information.¹² Data sharing can be further hampered by insufficient resources, including a lack of executive leadership, inadequate funding for staff and infrastructure, and limited technical capabilities.^{12,15,14} Finally, cross-sector data sharing can help maintain the status quo and perpetuate — or worsen — inequities by reinforcing racist policies and practices or enabling inequitable resource allocation.^{15,16}

Our goal in studying established IDS is to understand which factors appear to be critical for successful cross-sector data-sharing efforts. Although we focus on just one core enabler of cross-sector alignment,² developing and implementing IDS requires alignment across various stakeholders, and our findings can therefore inform other dimensions of cross-sector partnerships

METHODS

We conducted a total of 16 interviews: four with national experts in cross-sector data sharing and 12 with stakeholders in two states (Oregon and Washington) with operational IDS. Table 1 shows the key feature of IDS in each of these states. Our state interviewees included state officials in health and human services agencies, as well as external researchers and consumer advocates. We identified study informants through an environmental scan of publicly available IDS information and through a snowball approach, whereby interviewees provided us with suggestions for additional interviewees. We conducted phone interviews between March and August 2020, and subsequently transcribed and analyzed the interviews to identify key insights and common themes. Because we interviewed a small number of stakeholders, we may not have captured some important experiences and perspectives, particularly from outside of government.

Table 1. Key Features of the IDS in Two States: Washington and Oregon

| | WASHINGTON | OREGON |
|--------------|--|--|
| IDS | Integrated Client Database (ICDB) ^{17,18,19} | Integrated Client Services (ICS) ^{20,21} |
| Organization | Developed in 1995 and maintained by the Research and Data Analysis Division (RDA) within the Department of Social and Health Services (DSHS) | Developed in 2005 and maintained by the Office of Forecasting, Research, and Analysis (OFRA) within the Department of Human Services (DHS) |
| Purpose | Integrates and warehouses risk, service utilization, expenditure, and outcome data for individuals served by the Washington state DSHS, Health Care Authority, and Department of Children, Youth and Families Pulls in data from more than 30 state agency data systems | Matches individual-level data from programs within DHS, the Oregon Health Authority, and external agencies such as the Department of Corrections, Housing and Community Services, and the Youth Authority Pulls in data from more than 15 state agency data systems |
| Data Topics | Birth outcomes, mortality, health care and public health, child welfare, early childhood, education, justice, economic security (e.g., TANF, SNAP), homelessness/housing, federal (e.g., CMS, VA) | Birth outcomes, mortality, health care and public health, child welfare, early childhood, education, justice, economic security, homelessness/housing |
| Functions | Supports policy-driven analytics to perform program evaluation, performance measurement, predictive modeling, forecasting, geographical analysis, and policy analysis | Supports planning, reporting, forecasting, informing policy, measuring performance, and research and analysis |

FINDINGS

Many of the facilitators, barriers, and strategies uncovered in our interviews were consistent with prior IDS research. Key interview informants commonly cited leadership, organizational culture, and legal considerations as important factors in promoting or hindering data-sharing efforts. Informants also identified approaches — including a governance process — that can help to overcome barriers to data sharing, promote greater use of data in policy and program decisions, reinforce collaboration among distinct partners, and help institutionalize and sustain data-sharing practices. Table 2 summarizes frequently cited factors and strategies for cross-sector data sharing, which we discuss in more detail below.

Table 2: Factors and Strategies for Cross-Sector Data Sharing

| CONTEXTUAL FACTORS THAT AFFECT DATA SHARING | STRATEGIES THAT PROMOTE DATA SHARING |
|---|---|
| <ul style="list-style-type: none">• Privacy laws• Leadership buy-in• Organizational culture• Public mistrust• Crisis events | <ul style="list-style-type: none">• Create legal framework• Establish data governance• Promote data literacy and analytics• Invest in people and relationships |

Contextual Factors That Affect Data Sharing

Our informants identified five key factors that impact data sharing.

Privacy Laws

Interview informants frequently cited federal and state laws and regulations that guide administrative data use as a major challenge for data-sharing efforts. Informants recounted stories of drawn-out data-use negotiations and projects that never materialized because of data owners’

inability or unwillingness to navigate ambiguous and narrowly defined federal guidance on how data can be used for research and analysis. Further, concerns about violating existing legal statutes have allegedly led some agencies to totally forego sharing data or, at best, have made the sharing process long and painful.

Leadership Buy-In

Almost unanimously, our informants named executive-level leadership as one of the most important and effective factors in promoting data use and sharing across state government departments and agencies. Although some informants noted that a legislative mandate or executive directive can support greater data use in public policy, such requirements can be ineffectual without real leadership on the issue.

Leadership buy-in is necessary to secure funding for both the staff and infrastructure needed to support data collection, sharing, and analysis, as well as to guide data-sharing initiatives through challenges (such as navigating privacy laws). Indeed, a lack of leadership buy-in can be detrimental to data-sharing efforts. As one informant explained, the power of a good leader is in demonstrating how to use data in decision-making and everyday operations, and in fostering an organizational culture in which data is understood and valued.

Organizational Culture

Informants identified ways in which organizational culture can create barriers to data sharing, such as by lacking commitment to sharing data, overprotecting data, and the inherently siloed nature of government workflows.

For example, one informant noted that governments tend to overemphasize data collection — often in response to reporting requirements — and underemphasize data use to inform decisions within their own agency’s realm, let alone in the realms of other stakeholders. Similarly, government agencies often prioritize service delivery over data development, particularly when budgets are tight. Even if agencies collect the data, a lack of prioritization and investment in data quality and analytics infrastructure can undermine data integrity, which further disincentivizes data sharing.

Many informants emphasized an agency’s protectiveness over its own data as a key barrier preventing some data-owning institutions from sharing their data with others. Sometimes, this

protectiveness stems from concerns about the potential of data misuse or misinterpretation, but informants also noted that some data owners shy away from data sharing to avoid embarrassment if their data were found to be of poor quality or analyses showed that a program is underperforming compared to similar programs.

Another deterrent to data sharing cited was *siloing* — that is, limited interactions with other agencies and departments across and outside of a particular state government. An organizational culture in which interagency collaboration is not actively promoted (or is discouraged outright) does not easily lend itself to cross-sector data-sharing efforts. Some informants cautioned that even when various agencies are consolidated into one department, it does not necessarily lead to better data exchange among previously siloed agencies. Factors such as protectiveness (of one’s turf, for example) can be difficult to uproot, and building relationships and trust across agencies takes time and resources that may be difficult to sustain if not prioritized; hence, the importance of leadership buy-in.

Public Mistrust

Consistent with findings in the literature, several informants noted that public mistrust of government data-collection activities can jeopardize the collected data’s accuracy and comprehensiveness if, for example, program participants are reluctant to provide their personal data or give permission to agencies to share their deidentified data with other entities. In addition, heightened public scrutiny of government data collection following publicized data breaches may make data-owning entities less willing to participate in data-sharing initiatives.

Some informants said that public mistrust and the general population’s lack of data literacy also make it difficult to engage program beneficiaries and community members in decision-making about data. As data-sharing experts recognize, data collaboratives rarely engage individuals and communities whose data they are collecting and integrating. Consequently, the power over data typically rests with the entities that collect them, as opposed to with the “data subjects.”

Moreover, access to administrative data is often inequitable; for example, data are more accessible to university researchers than to community-based organizations. One informant suggested that, at a minimum, organizations that are collecting information from individuals need to be transparent about why and how their data will be used and protected. Several publications

offer guidance to data administrators on how to inclusively engage all relevant stakeholders — including individuals and communities — in data discussions (see Resources 1, 2, 8, and 11).

Crisis Events

Finally, some informants noted that crisis events can serve as both an impetus for and a hindrance to cross-sector data sharing, either by highlighting the need for data and data collaborations to effectively respond to the crisis, or by constraining resources for data work. To address the opioid epidemic, for example, Massachusetts recently developed a cross-sector database to inform more systematic and targeted interventions²².

Several informants suggested that the COVID-19 pandemic could spur similar cross-sector data-integration efforts, as states that have a history of data use and data sharing in public programs may harness these capabilities more effectively when a crisis hits (see Appendix 1, resources 3, 9, and 11). Washington state developed a publicly facing COVID-19 Data Dashboard to inform the state's reopening strategy by adding new data sources to its existing IDS.²³ On the other hand, some noted that crises could undermine data-related activities if governments prioritize funding services over data development.

Strategies that Promote Data Sharing

Our informants identified four key strategies to promote data sharing.

Create a Legal Framework

Collaboration partners can overcome the challenges related to navigating privacy regulations by establishing an appropriate legal framework driven by the data-sharing initiative's needs and objectives. For example, a legal framework for linking individual-level data for case management will differ from one in which data are linked but analyzed only on an aggregate level (see Appendix 1, resources 4 and 6).

One informant said that reframing research questions so that they are within the bounds of allowable data use could facilitate access to particular data sets. For example, state education

departments may be more likely to give permission to link education data with data from other sectors if the inquiry's primary objective is to evaluate childhood outcomes related to the education system rather than to noneducation systems. Informants also said it would be helpful to have clearer federal and state guidance on allowable administrative data use for research and analysis.

Finally, several people pointed out that each state department and agency typically has its own set of rules, procedures, and documentation requirements for releasing data, which can become burdensome when requesting data from multiple agencies. Establishing IDS can help standardize and streamline data-sharing processes. For example, the Research and Data Analysis Division that operates Washington state's IDS developed a set of standard data-sharing agreements for each data contributor that can be easily tailored for specific projects²⁴.

Establish Data Governance

Informants overwhelmingly cited data governance as a key strategy for facilitating transparency and accountability in data collection, linkage, protection, and use. Establishing agreed-upon written protocols about how, by whom, and for what purposes data will be linked and used can ease data owners' data-security concerns (see Resources 1, 5, and 7).

Several informants said that while executive leadership buy-in is essential to data-sharing initiatives, agency leaders might not have the technical expertise to make decisions about data-sharing policies and terms of use. Given this, governance bodies should include midlevel program staff and skilled data analysts who are deeply knowledgeable about agency programs and data capabilities.

To cultivate trust and overcome data protectiveness, informants suggested three effective practices:

- Engage data-owning agencies in governance;
- Promptly notify them of any inquiries or projects that involve their data; and
- Seek their input when interpreting findings.

Although the literature encourages the engagement of program participants in IDS governance — and the experts we interviewed described doing so as a best practice — we found

that this is rarely implemented in practice for reasons discussed earlier.

Promote Data Literacy and Analytics

Although having a data-sharing champion at the leadership level is critical, many informants noted that frequent turnover in leadership positions could easily undermine data sharing and usage practices if an organization does not instill the value of data sharing in its culture. Further, state governments need to focus on valuing data at all organizational levels, from the data collection point all the way to data analysis, interpretation, and presentation to decision-makers (see Appendix 1, resources 5 and 10).

Informants identified several ways in which organizations can cultivate this shared appreciation for data and promote data literacy, including to:

- Build internal data analytics capabilities (e.g., by hiring skilled data analysts),
- Educate staff about data importance, and
- Elevate the role of research and analysis in agency functions.

According to one interviewee, data's importance can be further demonstrated by investing in data-collection practices, which ensures a commitment to quality data collection and ultimately increases trust in data and data analytics. States can also establish an office responsible for managing all state data and analytic activities to maximize data's value and utility in policy and programmatic functions; some states, for example, hire a chief data officer.

Invest in People and Relationships

Finally, multiple informants emphasized that people and relationships are at least as important to data-sharing initiatives as the technology and infrastructure that underpin IDS. Although technology obviously matters, informants noted that even the fanciest analytics platform will not realize its full potential without the right people at the table who understand data and can establish and maintain effective relationships and agree on a shared purpose for data sharing.

In particular, informants highlighted the role of midlevel staff expertise in driving data-sharing initiatives; often these staff can shape organizational decisions, facilitate conversations

with agency leaders, and develop policies and standards for data use and exchange. Data practices and tools that are institutionalized across the organization help sustain the data focus even when leadership and policy priorities change.

A few informants warned against outsourcing data analytics to external consultants, which they said can cause many problems, including losing access to the data. Instead, informants recommended focusing on building internal capacity both in infrastructure and in the personnel needed to understand and use data effectively.

Furthermore, established data-sharing initiatives, such as IDS, can facilitate cross-sector collaboration because, rather than being just a one-off project, IDS create infrastructure in which organizations can continually link and analyze data and add new data sources, thus opening doors to additional inquiries and partnerships. According to our interviewees, partners who realize the potential of integrated data and become more savvy users of IDS may become more motivated to pursue cross-sector projects, which further enhances cross-sector collaboration.

DISCUSSION

IDS are a promising tool for harnessing the power of cross-sector data. They can help organizations develop a comprehensive understanding of a community's complex health and social needs, identify possible solutions, and measure the impacts of interventions on the health and well-being of individuals and their community.

Many organizations considering cross-sector partnership to advance health outcomes are intimidated by the technical demands associated with building expansive data infrastructure. We found, however, that data-sharing initiatives are often about people, relationships, and trust. As one of our informants described it, data sharing is about relationship management. People are an organization's most essential asset for driving change, whether they are cultivating data literacy, establishing reciprocal relationships that enable effective collaborations, or giving meaning to data and acting upon it. It takes people — including executive leaders, midlevel program staff, and data analysts — to create a culture in which data-driven approaches to everyday operations, policy challenges, and everything in between are second-nature. In the end, even an organization that builds the most sophisticated data analytics engine needs skilled people to translate its output into

ideas and to develop policies and implement programs that effect change.

The ultimate lesson for successful cross-sector collaborations is the importance of developing trusting relationships, including with the general public. Governance was highlighted by many as a key mechanism that can facilitate buy-in and trust-building among data collaboration partners, reinforcing its fundamental role in cross-sector partnerships.² We also learned that effectively engaging key stakeholders in governance can help overcome mistrust of data-sharing initiatives, and yet community members are often underrepresented or missing in discussions and decisions about data. This suggests that — while strong community engagement is a key underpinning of cross-sector alignment efforts² — finding ways to meaningfully and authentically engage community representatives in cross-sector alignment’s data-sharing component remains a challenge.

Cross-sector partners can engage and build trust with the public around data in three key ways. First, they can be transparent about which data are collected and how they are used, such as by investing in communications with program participants and the public. Second, they can include community representatives in developing, managing, and overseeing cross-sector data-sharing and analytic activities, such as through partnerships with trusted community-based organizations. Finally, they can strengthen the analytic capacity of community-based organizations, such as by providing training and education on research and program evaluation.

DATA SHARING AND INTEGRATED DATA SYSTEMS RESOURCES

Following are resources to help facilitate various aspects of data sharing, as well as several organizations that offer additional information and support.

Guides and Toolkits

- **Accountable Communities for Health: Data Sharing Toolkit** (<http://choir.berkeley.edu/ach-toolkit>). This toolkit offers guidance and insights on how to improve data sharing across sectors to drive better health outcomes. Drawing on the Communities for

Health concept, the toolkit walks users through seven key parameters for effective data sharing: purpose, relationships/buy-in, funding, governance and privacy, data and data sharing, technical infrastructure, and analytic infrastructure.²⁵

- **Centering Racial Equity Throughout Data Integration** (<https://www.aisp.upenn.edu/centering-equity>). This toolkit, produced by Actionable Intelligence for Social Policy (AISP), offers both exemplary and problematic practices for employing racial equity framing throughout the six-phase data life cycle. The toolkit provides guidance to a wide audience of stakeholders seeking to center racial equity in administrative data sharing.²⁶
- **COVID-19 Data Sharing** (<https://www.aisp.upenn.edu/covid-19-data-sharing>). This is a collection of AISP's network activities on state and local data-sharing efforts in response to COVID-19. Network sites have utilized integrated data to create dashboards and other visualization tools to relay updates about the virus — such as tracking cases, capacity, and resource use — to policymakers.²⁷
- **Handbook on Using Administrative Data for Research and Evidence-Based Policy** (<https://admindatahandbook.mit.edu/index.html>). This comprehensive handbook offers guidance for policymakers, researchers, and data providers on how to increase their use of administrative data to inform evidence-based decision-making.²⁸
- **IDS Governance: Setting Up for Ethical and Effective Use** (<https://www.thencit.org/resources/ids-governance-setting-up-ethical-and-effective-use>). This guide contains the best IDS practices related to governance, including building a vision, mission, and principles on ethical IDS use; stakeholder mapping; establishing common policies and procedures; considering key governance and security documents; and examining IDS staff capacity (e.g., skills, competencies and training).²⁹
- **Legal Guide to Administrative Data Sharing for Economic and Workforce Development** (http://www.statedatasharing.org/data-sharing/2018-03_-_SDS_

Legal_Guide_to_Administrative_Data_Sharing_for_Economic_and_Workforce_Development.pdf). This guide, produced by the State Data Sharing Initiative, features guidelines for understanding data confidentiality laws and developing data-sharing agreements to uphold the protection and security of administrative data.³⁰

- **National Neighborhood Indicators' Partnership (NNIP) Resource Guide to Data Governance and Security** (<https://www.neighborhoodindicators.org/library/catalog/nnips-resource-guide-data-governance-and-security>). This guide provides resources and best practices for developing strong data governance and ensuring data security.³¹
- **Nothing to Hide: Tools for Talking (and Listening) About Data Privacy for Integrated Data Systems** (<https://www.aisp.upenn.edu/resource-article/nothing-to-hide-tools-for-talking-and-listening-about-data-privacy-for-integrated-data-systems>). This step-by-step toolkit provides IDS stakeholders with tools and strategies to support and lead privacy-sensitive and inclusive stakeholder-engagement efforts.³²
- **Responsible Data Use Playbooks** (<https://playbooks.brighthive.io>). Aimed at public and private-sector leaders, this guide describes how to design and implement data-sharing collaborations to increase the impact of their COVID-19 response and recovery plans.³³
- **Unlocking the Value of Data Sharing: A Look Across Five Sectors** (<https://dashconnect.org/2018/09/04/unlocking-the-value-of-data-sharing-series>). This publication offers guidance on how to identify cross-sector partners and develop a common purpose for data sharing.³⁴
- **Why Am I Always Being Researched? COVID-19 Edition** (<https://chicagobeyond.org/researchequitycovid19>). This guidebook, produced by Chicago Beyond, helps community organizations, researchers, and funders address unintended bias in research, specifically as it relates to COVID-19.³⁵

Organizations

- **Actionable Intelligence for Social Policy (AISP)** (<https://www.aisp.upenn.edu>) is a national organization offering various resources and insights on the value of data sharing. AISP operates a network of 26 IDS run by state and local governments with cross-sector data agreements across multiple projects for policy and program improvement. It also has 10 learning communities of state partners working to develop their data-sharing capacity.
- **BrightHive** (<https://brighthive.io/>) is a data technology company that operates a Data Trust program to provide partners with a legal, governance, and technical framework to securely integrate data across sources and increase their collective impact. In response to COVID-19, BrightHive has also designed *Responsible Data Use Playbooks*, which include information on data sharing in contact tracing and in job-seeking activities for recently laid-off workers.
- **Data Across Sectors for Health (DASH)** (<https://dashconnect.org>), supported by the Robert Wood Johnson Foundation, is an initiative led by both the Illinois Public Health Institute and Michigan Public Health Institute to promote data-integration efforts for more-effective public health interventions and policies.
- **State Data Sharing Initiative** (<http://www.statedatasharing.org>), sponsored by the Center for Regional Economic Competitiveness, aims to advance better evidence-based policymaking by promoting the exchange of state administrative records to inform policy analysis and program evaluation.
- **Stewards of Change Institute** (<https://stewardsofchange.org>) is a nonprofit think tank that promotes information sharing to drive improvements in individual and community health and well-being. Further, through its National Interoperability Collaborative (NIC), Stewards of Change aims to build a network to advance data sharing across sectors to address social determinants of health.

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COMMUNITIES JOINED IN ACTION: FACTORS THAT IMPACT PROGRESS IN CROSS-SECTOR PARTNERSHIPS





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Communities Joined in Action (CJA) is an organization committed to supporting community partnerships and shared learning across the United States. To help inform these efforts, we conducted a study aimed at providing insights into cross-sector partnerships and factors that *impede* or *accelerate* progress toward partnership goals and objectives. As we describe here, our focus was on investigating the structures, functions, relationships, and policy dynamics in these complex partnerships. We examined both *internal factors*, such as organizational structures and functions, and *external factors*, such as public policies, power dynamics, and approaches to stakeholder engagement that impact cross-sector partnership design, functionality, and sustainability.

We paid particular attention to *partnership dynamics* — that is, *why* stakeholders came together, *how* they are evolving, and *in what ways* the internal and external factors influenced the partnership. Further, because CJA is community-focused, we were interested in *how the community voice is reflected* in various partnerships and settings: How does engagement occur, and how is trust built? In what ways do partnerships at different geographic scales build trust? How does this trust impact the achievement of various goals and objectives?

BACKGROUND

Cross-sector partnerships vary in the degree to which they engage community stakeholder groups and lay residents in design, planning, implementation, evaluation, and decision-making processes. Such engagement, however, is challenging and often limited for many reasons, not least because people with limited resources have less time and flexibility to participate in processes outside of meeting the near-term needs of themselves and their families.

Proprietary orientation and competitive dynamics among health care organizations are also obstacles to genuine engagement. Likewise, many institutions and organizations in related sectors have operated for decades with inadequate resources from federal and state public-sector agencies and often lack the capacity to take on new responsibilities and test new innovations. Further, decades of underfunding have contributed to a “brain drain” in our local public health agencies¹ with growing percentages of leaders retiring, while others choose career paths that offer greater potential for advancement and greater opportunities to make a difference.

Researchers are increasingly recognizing the benefits of having a common management and oversight structure to serve as a neutral convener, facilitator, and monitor of complex cross-sector partnerships.^{2,3} This “backbone”⁴ entity provides a framework to support definitive and sustainable action that makes a difference in people’s lives. The backbone concept, advanced almost a decade ago, can help partners better address practical realities — most significantly, institutional racism — that add an additional layer of challenge for communities of color.⁵

A cross-sector partnership’s geographic scale — that is, community, municipality, county, or region — has significant implications for institutional engagement, public policy reform, and community participation. Many believe that securing the robust participation of community members requires a focus at the scale of *community*, which is typically a subset of a municipality or other jurisdiction.⁶ Others suggest that a partnership at the *municipality* or county scale provides levels of accountability and public-sector engagement that offer greater potential for achieving identified goals and objectives. Still others see potential with cross-sector partnerships at the *regional* scale; such partnerships challenge the involved jurisdictions to break down silos and align resources, thus offering greater potential to leverage institutional systems change, secure support from state agencies, and implement policy reforms.⁷

With these issues in mind, we selected six partnership sites for our inquiry: two at the regional level, one rural site at the county level, one at the city level, and two at the community level. Following our study’s completion, we convened two focus groups with national leaders and community members to discuss the findings.

METHODS

We carried out site selection with input from CJA board members, as well as from other colleagues with experience working with community health partnerships. Our site-selection criteria included:

- A cross-sector focus;
- Engagement of health care stakeholders;
- Engagement of community stakeholders;

- An emphasis on shared governance and decision-making; and
- Use of common metrics and monitoring systems.

Additional considerations included diversity in population type (i.e., urban, suburban, rural); scale (i.e., community, municipal, county, region); race, ethnicity, and culture; state/local policy dynamics; and geography.

We connected with focus group attendees through CJA board members, who identified collaborative partnerships and stakeholders across the United States. We conducted a total of 24 key informant interviews with representatives of the six cross-sector partnerships. The interviewees included representatives from the partner health care organizations (one from each), 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 leader of the organization that manages the partnership. Interviews were recorded and conducted virtually with video to capture complete information and foster an environment of trust and engagement. We supplemented the resulting data with feedback from two focus groups that included social service, health care, public health, and community residents.

FINDINGS: INTERNAL FACTORS

We identified two major internal factors on which to base our inquiry — structures and functions, and leadership engagement — to explore how cross-sector efforts could impede or accelerate partnerships.

Structures and Functions

We asked the health care informants to identify their organization’s primary objectives in the partnership and what they view as their *theory of change* — which we described as the changes they envision as organizational outcomes associated with their participation. One informant noted that their hospital “has a long way to go” to take the social determinants of health (SDoH) seriously and that progress is driven more by the larger health system’s investments than by local hospital

leadership.

Another key informant said that their system sees upstream investments as a way to prevent both unnecessary, low-value care and human suffering. The informant said that their accountable care organization is “influential in flipping the investment” but that it is focused primarily on care management. The organization’s theory of change is to choose upstream investments with measurable outcomes to build internal skills that can be applied to other conditions.

We asked key health care informants to describe whether and how their participation in the partnership supports movement toward value-based payment. Progress to date varies across sites and health care partners, but many noted that health care providers are engaged in work to address the SDoH primarily because their mission indicates a commitment to improving health and well-being.

Informants note that community stakeholders are building relationships with clinical partners and view this as laying the groundwork for potential gain-sharing agreements in the future. As one informant put it, “A big part of building institutional support is figuring out how to do the work without anyone saying you can’t.”

Leadership Engagement

Some informants acknowledged a gap between the engaged representatives and senior leadership in understanding both the partnership’s importance and how it will help achieve their organization’s strategic objectives. Informants also cited a significant loss in the quality of organizational representation and relationships with partners when senior leaders of larger institutions delegate engagement to people without decision-making power. As some informants noted, in such a situation, other stakeholders understand this delegation as a cue that these larger partners — typically, health care institutions — view the partnership as having limited relevance to the organization’s core strategy.

FINDINGS: EXTERNAL FACTORS

To ensure a comprehensive view of factors outside of the scope of organizations, our team identified

three areas in which to gather feedback: historical/structural power dynamics, public policy, and stakeholder engagement. In our view, exploring these and the aforementioned internal factors can provide us with a comprehensive view of potential factors to increase these very important partnerships.

Historical/Structural Power Dynamics

We asked key informants to share their observations on the historical and structural dynamics at play in their partnerships that either impede or enhance progress toward identified goals and objectives in some way. For all six partnerships, balancing large institutions' power with the interests of community stakeholders is a continuing challenge. One informant cited a disconnect between researchers and communities that is perpetuated by intimidating communication styles and reinforced by the fact that institutional — rather than community — interests drive funding priorities. Another informant suggested that health professionals and researchers need coaching on how to genuinely engage residents.

One health care informant drew parameters around acceptable partnership topics, indicating as unacceptable the goal of rationing the care delivered across competing systems in the region. This highlights the challenges faced by partnerships involving competing hospitals with different goals for transformational change. One site manages these competitive dynamics through multilevel initiatives that align with different organizational objectives; this contributes to engagement as each organization seeks to protect its interests. The power and resource differential between large organizations and community-based organizations is difficult to resolve unless leaders of the large organizations clearly commit to fundamental change. Further, several informants cited the lack of resources for community leadership development as a structural obstacle to progress. As one interviewee described it, people sometimes start out as receptionists or volunteers in community-based organizations and then rise to the executive director role without having access to leadership skill-building tools and resources to support their collaboration with others to solve complex problems.

Another obstacle to achieving partnership goals and objectives are the “bandwidth” limitations among related sector partners. One informant noted that their city's mayor sees the

partnership as “owned” by a health care stakeholder and thus as an opportunity to focus his time elsewhere. A public health interviewee at another site noted that their public hospital views public health as “having the county covered,” representing a missed opportunity to manage care across providers.

Public Policy

We asked key informants to identify public policies at the local, state, or federal level that have or could enhance or impede the achievement of their goals and objectives. In Oregon, informants said that the most direct influence of state public policy was the reform process to establish coordinated-care organizations and regional health councils. One of the reform’s key contributions is to modernize public health functions through cross-jurisdictional sharing of staffing and responsibilities.

Interviewees more often cited the *lack* of action or inflexibility in state policy as impediments to progress. As one key informant noted, “unspoken rules are more prevalent than those in statute,” and state agencies need to remember that different jurisdictions are unique and flexibility is needed to take advantage of different strengths and dynamics. The community-scale partnerships cited work on fair housing policies and zoning as positive accomplishments, and a need for greater parity in services within and beyond municipal boundaries as a challenge. Other informants called for states to consider the difference between urban and rural counties; doing so would provide flexibility in determining the best use of available funds.

Stakeholder Engagement

Stakeholder engagement involves three key elements: governance, community resident engagement, and cross-sector engagement.

Governance

We asked leaders to describe their organization’s role in advancing the partnership goals and objectives. One leader described the partnership metaphorically as a winding road, with their organization’s goal being to assist partners in navigating the twists and turns, identifying “lanes”

as having either exclusive use or overlap, and leveraging different strengths that help to achieve objectives.

All leaders described their organization as a type of “backbone” for the partnership, ensuring alignment of goals, fidelity of implementation, funding, and sustainability. Key informants acknowledged the fragility of their partnership, both in terms of funding security and ability to drive the process given tendencies among large health care providers to “medicalize” strategies for addressing the SDoH. One informant emphasized the importance of an independent perspective and strong mediation to proactively address friction among partners.

Community Resident Engagement

We asked informants in each of the four categories about issues related to engaging community residents. In their responses, informants distinguished between the professionals who live in communities of focus and represent community-based organizations, health care, and related sector institutions, and the community residents that these organizations and institutions serve.

One key informant lamented the limited engagement of residents, noting that the dialogue would benefit from the participation of ordinary people who know what it’s like to deal with the local health system. Another expressed appreciation for partners at the table that represent the community but said that they did not have equal status in meetings. Multiple informants emphasized the work needed to ensure a focus on equity, race, education, and social status, and the importance of having partners from different backgrounds asserting leadership at different times.

Partnerships at the municipal or regional scale identified obstacles to ongoing community resident participation on partnership boards and committees; such obstacles range from time commitment for younger parents to lack of transportation. One informant noted a shift in focus to grandparents as an important source of practical knowledge and wisdom; another mentioned that their organization is engaged in a dialogue about establishing and supporting an independent community advocacy group. In some cases, community members are paid stipends, and an effort is made to encourage candor in raising issues with institutional leaders. While our informants agreed that stipends and childcare are important — and are being pursued to varying degrees — at least one noted that public-sector agency “red tape” presents obstacles.

One regional partnership receives state support for community engagement and has 250-300 community volunteers that participate in six monthly workgroups. Another is in the process of creating a separate community advisory council with stipends and childcare support to ensure active participation. One community-scale partnership has bylaws that require community leadership, and each work track ensures parity between an institutional partner and a community resident partner, and both are included on the executive board.

Informants from related sectors indicated that while community voices are expressed through various committees, as well as through the community health needs assessment and public health accreditation processes, more work is needed to further amplify community voice through regular input and engagement. One informant also noted that the voices of some community leaders dominate at the expense of others, undermining the potential for a deeper understanding of issues. Further, as partnerships move into local and state policy issues, informants said it was imperative to build common knowledge among residents of legislative, licensing, and regulatory dynamics and their implications for life on the ground.

While several informants emphasized the importance of training and coaching for engaged community residents, one emphasized that a similar process was also needed for organizational and institutional representatives. Such training for professional partners ranges from providing information on the community to encouraging “leave the suit and tie at home” messaging to reduce the potential for intimidation and the communication barriers it creates. Finally, informants said that without explicit encouragement to share knowledge, residents may become passive, disenchanted, and disengaged.

Cross-Sector Engagement

All key informants said that COVID-19 created an imperative for fundamental change, highlighting profound inequities in communities and presenting daily challenges at the individual, departmental, and agency levels. It is urgent that community-based organizations, hospitals, and public health and state agencies break down silos to get resources into communities in a timely and strategic manner. COVID-19 has also spurred new thinking, with efforts to reduce the impact of trauma and take a robust approach to civic engagement. Further, the expanded use of telehealth has contributed to new thinking about building community interdisciplinary capacity.

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. They also said attention is needed to diversify revenue streams, bringing in contributors from outside the physical health arena — such as partners from social service, community, education, and foundations — to reduce the demand for preventable utilization.

For example, one regional partnership engaged a higher education institution and created an array of new opportunities to build the region’s population and public health capacity. The school has also taken new steps to expand its education pipeline across disciplines. In the health sector, it recently shifted the psychiatry residency to a community-based program in response to a dire need for such services in the region and the state. Another regional partnership is working with the United Way to serve communities in a more strategic way, given that providing small grants to social service agencies over the past 75 years has not moved the needle.

In one municipal partnership, the county public health agency is replicating quality improvement’s codesign process and integrating its principles to ensure ongoing monitoring and refinement of efforts in other communities. Similarly, in another county partnership, engaging other sectors has helped illuminate a new vision for the public health agency. The partnership has demonstrated the capacity to be nimble, adjusting its plan as the state shifted its strategy. In one of the regional partnerships we studied, the public health agencies began hiring high school students for social messaging on key issues such as tobacco. These students help get messages out in school and speak with county commissioners; for many of them, the opportunity offers an entry point for considering health careers.

DISCUSSION

Our study’s purpose was to provide insights into cross-sector partnerships and factors that impede or accelerate the achievement of partnership goals and objectives. As a qualitative inquiry, our intent is to share perspectives and stories to inform others as they travel similar paths. Although some of these learnings are more applicable to one context or community than others, following are a few overarching reflections for anyone engaged in or considering an intersectoral partnership.

Scale Matters

Regional initiatives offer significant potential to rationalize services within and across jurisdictional boundaries in a way that optimally utilizes differential expertise to achieve economies of scale. Such initiatives, however, also face increased challenges when engaging diverse community stakeholders and may impose solutions that fail to reflect the priorities or best interests of community residents.

Competitive Dynamics Die Hard

A spirit of collaboration among competing health care providers and payers is essential to facilitate the data sharing and asset leveraging required to build an evidence base. This spirit of collaboration, however, can be hard won. In some cases, senior leaders may keep partnerships at arm's length, delegating participation to people who lack decision-making power. This draws lines that may limit the collaboration's potential impact.

Sustainability Requires Funding Stability

The historically based and geographically concentrated inequities addressed by these partnerships are not easily eliminated — especially within the parameters of the typical two- to three-year grant period. As such, it is critically important that backbone organizations secure stable and sustainable funding, such as through longer-term partner commitments, return-on-investment arrangements, and public-policy-driven funding streams.

Community Resident Engagement Is Tricky, but Critical

While there are many obstacles to community resident engagement, there is ample justification for making the effort at every geographic scale. As our informants repeatedly highlighted, genuine engagement pays a range of dividends — from building political support for and avoiding turnover of local elected officials (and thus producing returns on those investments) to actively mobilizing and supporting interventions that are consistent with local priorities.

Policy Development: Aim for Institutional Change Over Short-Term Gains

Most funders focus on short-term projects and measurable impacts, which leads most partnerships to focus on “doing” things on the ground rather than on how gains can be sustained through institutional change and policy development. Given limited resources in philanthropy, there is rarely sufficient support on the front end for institutions to develop a comprehensive strategy tied to an organization’s long-term strategy or an infrastructure to manage the process. As a result, unless partnerships start with a planning process that links innovation to policy development, they will likely lack the connections, resources, expertise, and leverage to engage government agencies in creating one later.

CONCLUSION

We started this inquiry prior to the COVID-19 pandemic, but the lessons identified have been magnified due to the presence of the virus globally. As the world begins to move forward with vaccine rollout strategies, heal wounds from elections, and explore opportunities for economic recovery, the findings are relevant across sectors as there is an increased need for all to continue to work together.

In the near future, it may be helpful to explore potential research topics including the following:

- Conducting a large-scale comparison of existing cross-sector partnerships that successfully distributed vaccine with partnerships that may have struggled.
- Learning whether vaccine efforts helped increase engagement across sectors.
- Investigating how COVID-19 may have led to new innovations in local and federal policy as a result of newly identified inequities.

And finally, there is an ample opportunity to explore how our current dynamic of remote engagement and partnership may be useful as an ongoing tool to ensure more inclusive engagement from community members. By having the opportunity for health care institutions, public health

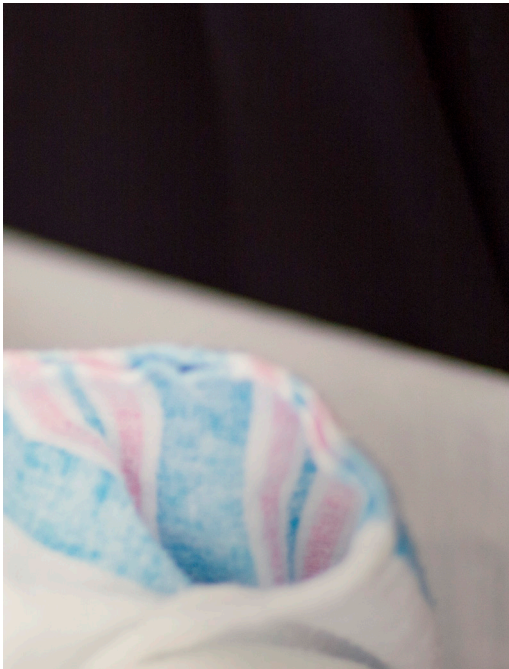
entities, community-based organizations, and community residents to log in to an online portal, it may help level the playing field and address potential concerns over power dynamics that have long existed in all partnerships.

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INSIGHTS ON CROSS-SECTOR ALIGNMENT USING THE PATHWAYS
COMMUNITY HUB APPROACH





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Although aligning services across health care, social services, and public health sectors is increasingly viewed as necessary for improving health outcomes,^{1,2,3,4,5,6} cross-sector alignment is challenging because organizations have differing practices, interests, and cultures. Here, we investigate the Cross-Sector Alignment Theory of Change and how its four components of alignment — purpose, data and measurement, sustainable financing, and governance⁷ — are addressed in communities that use the Pathways Community HUB (PCH) model to coordinate services for at-risk individuals.

Our study addresses four research questions (RQs):

- Do existing national PCH certification standards require and/or potentially encourage cross-sector alignment relating to shared purpose, data and measurement, finances, and governance? (RQ 1)
- How do community organizations using the PCH model perceive their alignment across the four components, and do their perceptions of these processes differ across sectors? (RQ 2)
- What factors appear to influence cross-sector alignment processes? (RQ 3)
- What kinds of impacts flow from alignment efforts under the PCH model? (RQ 4)

THE PCH MODEL

Under the PCH model, a central HUB serves as a community nerve center through which organizations network to assist at-risk clients. The HUB establishes relationships with the community's care-coordination agencies, which typically hire community health workers (CHWs) to enroll clients and assess their modifiable risks across medical, social, behavioral, and safety domains.⁸ Such risks might include lack of a medical home or housing, substance use/abuse, or inadequate transportation — to name just a few examples of risks that the PCH model can address.

CHWs employed by organizations using the PCH model use 20 standardized, nationally applicable Pathways⁹ to guide their efforts to ensure that risks are addressed. These Pathways reflect a range of risks and prescribe specific outcomes to be tracked and mitigated. Achieving these outcomes reflects the mitigation of risks for the individuals served. When mitigation efforts are

unsuccessful, results are documented as “finished incomplete” Pathways, which can be aggregated to highlight areas in which communities may need to expand their services.

The PCH model uses a pay-for-outcomes approach in which payers reimburse HUBs for completed Pathways (mitigated outcomes). HUBs then distribute that income to their care-coordination agencies, keeping some funds to cover their costs.

METHODS

To address our research questions, we assessed PCH Institute (PCHI) certification prerequisites and standards, and analyzed survey, interview, and other data from care-coordination, health care, social services, and public health organizations in three communities served by PCH networks.

For RQ1, we assessed the extent to which PCHI standards address the four theory of change components. To do this, we reviewed the 28 PCHI standards in place in 2019,¹⁰ defined key elements of the four components, and ascertained whether or not PCHI standards addressed them. Three of the four components included more than one conceptual element (in our interpretation, the data and measurement component had only one key element).

Consistent with these observations, we developed seven criteria to determine PCHI standards’ applicability to the four alignment components.¹¹ We coded PCHI standards to characterize the extent to which they apply to and/or require alignment-related activities of certified HUBs. This coding scheme had three classifications:

1. Not applicable
2. Applicable but not required (i.e., it might encourage alignment)
3. Applicable and required

In coding the standards, we focused on review items required by PCHI and the standards’ actual language.

For RQs 2, 3, and 4, we administered a written survey and conducted interviews with representatives from four organizations in each of the sample communities. Two of the communities are served by long-standing HUBs. These two HUBs — the Community Health Access Project

(CHAP) in Mansfield, Ohio, and the Hospital Council of Northwest Ohio's (HCNO) Pathways Community HUB in Lucas County, Ohio — were both certified in 2014 when the PCH certification program commenced. The third community we investigated is in Michigan and is served by the Northern Michigan Community Connections HUB (managed by a Michigan Community Health Innovation Region). It is a relatively new HUB that was compiling information to support its certification application during our study. Choosing these three case communities let us compare two relatively mature HUBs that have achieved certification and gain insights from a HUB that is at an earlier stage in its development process.

We began data collection with a written survey administered to each HUB's director or assistant director (hereafter, *director*) followed by an in-depth interview. We asked the directors to rate the extent to which their PCH partners were aligned across the four theory of change components on a five-point Likert scale (with 5 indicating “very high” and 1 “very low” alignment levels). We also asked the directors to provide contact information for HUB partners in the public health, social services, and health care sectors. We then sought to interview organizational leaders from those sectors in each community to determine their perception of their organization's alignment with the HUB across the four components. In one community, a public health partner was unavailable due to demands associated with the COVID 19 pandemic, so we interviewed two social services partners instead.

Drawing on prior literature on collaboration across organizations,¹² we asked the HUB directors about seven factors that could potentially influence community efforts to align services across sectors — five internal to the organizations or community and two external to them (see Table 1). We also asked about how PCHI standards impact community alignment efforts and invited the directors to identify other factors that influenced their cross-sector alignment work. We then asked whether or not each of the identified factors influenced alignment status, and if so, how.

We also asked the directors and sector-based partners about the impacts of their cross-sector alignment efforts. One set of our questions here focused on a realist perspective, asking what works, for whom, under what circumstances, and why.¹³ Another set of questions focused on recent quantitative Pathway-related information on risks identified and mitigated (or not) by

each HUB. We collected data between February and October 2020; our study procedures were reviewed by the institutional review boards (IRBs) of Akron Children’s Hospital and Kent State University.

Table 1. Factors That May Influence Collaborative Alignment Efforts

| FACTOR | HOW THE FACTOR IS EXPECTED TO INFLUENCE ALIGNMENT EFFORTS |
|---|---|
| Internal factors (within the community/organization) | |
| Demands and requests from citizens | Citizen demands yield collaborative alignment responses to address citizens’ needs. |
| Financial needs of partners/community | Financial needs yield collaborative alignment efforts to address them. |
| Previous failure to address a problem | Past failures — often by individual organizations — yield efforts to solve problems collaboratively. |
| Strong individual/organizational leadership | Strong individual/organizational leadership motivates collaborative alignment efforts. |
| Trust among partners | Trust among partners fosters collaborative alignment efforts. |
| External factors (outside the community/organization) | |
| External requirements/regulations | External regulations (federal, state, or other) incentivize or require collaborative alignment efforts. |
| Grant/funding requirements | Grant or funding requirements incentivize or require collaborative alignment efforts. |

FINDINGS

Overall, our findings suggest that the nationally standardized PCH care-coordination model can help communities align services across all four theory of change alignment components, both through its certification standards and through alignment efforts undertaken by individual communities. While the factors facilitating alignment progress appear to be multifaceted and potentially variable across communities, our findings also suggest that these efforts yield positive impacts for communities, at-risk clients, and the organizations involved.

RQ1 Findings

Our assessment of PCHI’s certification standards suggests that they support alignment among PCH partners across the four theory of change components. Viewed broadly, 96% (27 out of 28) of the standards addressed at least one of the four components of alignment in some fashion.

Table 2 provides more detailed information on the relationship between PCHI standards and the four components resulting from our assessment. It shows that at least six standards require documentation of activities consistent with each of the four components. Further, at least two standards are applicable and may therefore encourage alignment for each of the core components. Overall, the PCHI standards most frequently support alignment relating to governance (71%), followed by shared purpose (61%), data and measurement (46%), and finance (42%). As these results show, PCHI standards clearly support alignment across all four alignment components in PCH-served communities.

Table 2. Activities Required and Potentially Encouraged by PCHI Certification Standards

| ACTIVITY TYPE BY ALIGNMENT COMPONENT | PCHI STANDARD ASSESSMENT | | |
|---|--------------------------|---------------------------|-------------|
| | REQUIRED | POTENTIALLY ENCOURAGED | TOTAL |
| Purpose (vision and/or priorities) | 12/28 (43%) | 5/28 (18%) | 17/28 (61%) |
| Data and measurement | 9/28 (32%) | 4/28 (14%) | 13/28 (46%) |
| Finance (sustainability and/or accountability/incentives) | 6/28 (18%) | 6/28 (18%) | 12/28 (42%) |
| Governance (partner engagement and/or strong decision-making) | 18/28 (64%) | 2/28 (7%) | 20/28 (71%) |

RQ2 Findings

Our survey and interview data suggest that alignment is occurring in all three PCH communities in our sample. As Table 3 shows, responses from the 12 PCH partners we interviewed indicated “at least some degree” of alignment in these communities, as evidenced by average perceived alignment ratings of 3 or greater across all four components from both the HUB directors and their sector-based partners. On average, those we interviewed indicated “high” or “very high” alignment levels for purpose and relatively high alignment levels for data and measurement and shared confidence in decision-making. These three alignment areas showed only modest variation across the HUBs and sectors. We did find two exceptions here, however. One was from a director who indicated that their PCH network decision-making often occurred through operational decision-making within the HUB rather than through governance arrangements. Another exception was from a social services partner whose organization was relatively new to the HUB and thus had not fully incorporated the HUB’s priorities and data and measurement systems into its operations.

Estimates of alignment on finances and partner engagement in governance were generally more varied, but still exceeded an average rating of 3, thus suggesting at least some degree of cross-sector alignment in these areas. The most significant variation was reported for the finance component’s incentives and accountability measure; such variation is largely attributable to perceptions of the Northern Michigan PCH partners, whose HUB had not yet established pay-for-outcome contracts with payers (PCHI standards require such contracts, and the HUB is working toward full compliance with them).

We also found differing perceptions across sectors regarding financial sustainability. Although interviewees agreed that outcome payments alone were not yet sufficient to ensure PCH network sustainability, we found variations in perspectives across sectors. Overall, health care sector leaders reported higher levels of financial sustainability than directors and partners from other sectors. Public health partners indicated somewhat higher confidence in the sustainability of their PCH efforts than did HUB directors and social services partners, but slightly less than health care representatives. This relative confidence among public health leaders appears to be at least partially attributable to their view that the PCH network in their communities was closely aligned with their organizations’ role as a facilitator of population health services; they were thus

comfortable using their baseline funding sources (local funds, state financial assistance, etc.) to help cover costs of their PCH engagement. This same perspective may also explain why public health partners reported higher levels of governance engagement than partners from other sectors.

Table 3. Perceived Levels of Alignment by Component and Service Sector

| | PURPOSE COMPONENT | | DATA COMPONENT | FINANCE COMPONENT | | GOVERNANCE COMPONENT | |
|---------------------------------------|-------------------|---------------|----------------------|-------------------|-------------------------------|----------------------|-----------------|
| | Vision | Priorities | Data and Measurement | Sustainability | Incentives and Accountability | Partner Engagement | Decision-Making |
| Sample <i>n</i> | <i>n</i> = 12 | <i>n</i> = 12 | <i>n</i> = 10* | <i>n</i> = 12 | <i>n</i> = 11* | <i>n</i> = 12 | <i>n</i> = 10* |
| Service Sector | | | | | | | |
| HUB (<i>n</i> = 3) | | | | | | | |
| Mean | 4.67 | 4.67 | 4 | 3.33 | 3.67 | 3.33 | 3.33 |
| Range | 4-5 | 4-5 | 4 | 3-4 | 2-5 | 2-4 | 2-4 |
| Public Health (<i>n</i> = 2) | | | | | | | |
| Mean | 5 | 5 | 3.5 | 3.75 | 3 | 5 | 5 |
| Range | 5 | 5 | 3-4 | 3-4.5 | 3 | 5 | 5 |
| Social Services (<i>n</i> = 4) | | | | | | | |
| Mean | 5 | 4.25 | 3.33* | 3.25 | 3* | 3 | 4.33* |
| Range | 5 | 3-5 | 2-4* | 2-5 | 1-4* | 1-5 | 4-5* |
| Health Care (<i>n</i> = 3) | | | | | | | |
| Mean | 4.67 | 4.33 | 4.25* | 4 | 3 | 3.33 | 4.5* |
| Range | 4-5 | 3-5 | 4-4.5* | 3-5 | 1-5 | 2-5 | 4-5* |
| Overall (<i>n</i> = 12) | | | | | | | |
| Mean | 4.83 | 4.5 | 3.75* | 3.54 | 3.18* | 3.5 | 4.2* |
| Range | 4-5 | 3-5 | 2-4* | 2-5 | 1-5* | 1-5 | 2-5* |

*Indicates one or more omitted responses due to "I don't know" answer(s) to questions asked.

We also asked interviewees about the extent to which their PCH networks engaged local public officials — city or county council members, local administrators or managers, mayors,

etc. — in HUB governance. While some respondents indicated that they did not know, those who responded reported relatively low levels of local official engagement in PCH governance. One public health and one health care respondent suggested some alignment in this area, but most suggested low or very low levels of local public official engagement, with an overall average rating of less than 2 on a five-point scale. These respondents cited challenges in getting sustained attention from local public officials and a broader need to market the PCH model in their communities.

RQ3 Findings

The HUB directors reported that multiple factors contributed to their community’s cross-sector alignment efforts across the four theory of change components. Several observations are appropriate in this regard. First, four factors — *strong leadership*, *trust among participating organizations*, *past failure to address a problem*, and *external funding requirements* — were reported to have influenced alignment efforts across all four alignment components in all three case communities. Second, other factors — including *financial needs of the organizations involved*, *citizen demands*, and *external regulations* — were perceived to have influenced specific alignment components in a more targeted fashion. Third, *PCHI certification standards* reportedly influenced alignment efforts in the newer Northern Michigan HUB, while the directors of the other two HUBs provided more measured responses to our inquiries in this area because both of their HUBs were in operation prior to the certification program’s launch and their HUBs’ work informed development of the certification standards. A director from one of the certified Ohio HUBs, however, reported that certification did require them to “up their game” in the governance area. That director also reported that federal Affordable Care Act (ACA) community benefit requirements to justify hospitals’ nonprofit tax status encouraged hospital engagement in their PCH governance processes.

RQ4 Findings

Regarding the impacts of PCH alignment, we found similar observations across the three case study communities on questions relating to the realist perspective — that is, what works well, for whom, under what circumstances, and why. All three HUB directors emphasized the positive relationships that have developed across the organizations administering PCH services in their

communities. In addition, more than one representative in each PCH network reported that the HUB work benefited:

- At-risk clients, by addressing their needs and reducing their risks;
- Health care providers, by enabling referrals, which can help their patients address social and behavioral risks; and
- Partnering agencies, whose capacities are increased by their connection to the PCH network.

Others pointed out that successful PCH efforts to help clients find regular medical homes to address their health needs reduced unnecessary visits to community emergency departments; over time, this kind of impact will likely yield savings for insurance payers from reduced medical costs due to reduced client risks. Respondents also suggested that these and other benefits accrue primarily in circumstances where CHWs develop strong client relationships and where community resources and services are sufficient to address the identified needs. Respondents further suggested that their efforts succeeded largely due to relationship building by CHWs and the successful alignment of organizations to meet identified needs in the communities served.

We found notable differences in responses between the two mature and certified HUBs in Ohio and the newer (still developing) Community Connections HUB in Northern Michigan. For the certified HUBs in Ohio, health care and social services representatives noted the importance of having accountable payment structures built into the PCH model to incentivize productive work. In contrast, the newer HUB's health care and social services representatives focused on the value of a shared screening tool that they developed and used to track needs and outcomes across organizations. In addition, the Michigan health care representative noted the long-term potential for insurance payers to benefit from health care cost reductions due to cross-sector service provision, while an Ohio director cited a study of pregnancy Pathway services in their community that found a 236% return on investment associated with the insurance company's pay-for-outcome investments in the HUB and its partners.⁴

Not surprisingly, partners from different sectors often emphasized different benefits and challenges:

- Health care partners mentioned improved clinical outcomes, while noting challenges in integrating HUB data and measurement systems with existing healthcare data and financing systems.
- Social services representatives noted a wider range of positive outcomes for clients—such as employment and long-term self-sufficiency — and the importance of enhancing communitywide capacities to address identified needs.
- Public health representatives emphasized the PCH model’s transformative impact, as well as its ability to bring services into alignment across organizations to meet communitywide needs.

The HUBs also provided quantitative evidence of positive impacts flowing from their cross-sector alignment efforts. Collectively, they reported successful mitigation of more than 28,000 individual risks across their communities in 2019-2020. For example, data from efforts across the three HUBs reported the following:

- 135 clients attaining employment;
- 425 clients obtaining health insurance;
- 6,326 clients completing a medical appointment; and
- 208 clients becoming sustainably housed.

As expected, the numbers of risks mitigated through the two mature and certified HUBs exceeded those mitigated through the newer HUB. Rates of successful Pathway completion also appeared to vary based on the HUB’s developmental stage. While the newer HUB reported successful mitigation of approximately 50% of identified risks, the two mature and certified HUBs reported that more than 70% of their identified risks were successfully mitigated. Across all three HUBs, the data provided suggest that the PCH networks were relatively successful in addressing risks relating to medical referrals and obtaining health insurance coverage; helping clients to find housing and employment presented greater challenges.

Overall, the quantitative evidence provided by the directors illustrates two key points about the cross-sector PCH networks in the sample communities: they are using integrated PCH data and measures to guide their progress, and they are achieving meaningful reductions of targeted risks through their service alignment efforts

DISCUSSION

Our findings reveal that PCHI standards require certified HUBs and their PCH networks to take actions to align their services across the four theory of change alignment components. Partners implementing the PCH model also perceive that their cross-sector alignment benefits at-risk populations in their communities. Overall, partners perceive relatively high alignment levels around purpose, data and measurement, and decision-making, and some alignment around finances and partner engagement in governance.

Our findings also identify factors perceived to influence service alignment. Some factors appear to influence alignment across multiple theory of change components, while others appear to operate in a more targeted fashion. The factors driving cross-sector alignment also manifest themselves differently across communities, as well as in the two states represented in our sample. In the newer Northern Michigan HUB, state policies appear to have incentivized public health partners to play leading roles in the HUB's work, while in Ohio, managed care organizations are required to make outcome-based payments to the two certified HUBs. Our findings also suggest that PCH-based cross-sector alignment efforts produce benefits for both the individuals served and the organizations involved, including quantifiable benefits based on the numbers of individual risks identified and mitigated.

These findings have at least four key implications for our understanding of alignment processes and future research. First, they suggest that cross-sector alignment can and does occur in communities that use the PCH model. The PCH model provides a framework for developing cross-sector alignment efforts, both nationally and in specific states and communities. Indeed, having examined the results of this research, PCHI is now reviewing and improving its standards to pursue progress across the four alignment components more effectively. It has also indicated that it will share findings from this work — particularly those on perceptions of relatively low

engagement levels of local public officials — with members of its national PCH network.

Second, our findings reaffirm that aligning services across organizations is challenging and requires substantial time to enable progress. While all three communities demonstrate valuable benefits from their alignment efforts, quantitative measures of Pathway completion suggest that the two mature HUBs — which have been operating for more than a decade — may have been beneficially affected by having had more time to successfully address the challenges associated with cross-sector alignment relative to the newer Northern Michigan HUB. However, the newer HUB has built a substantial cross-sector network of organizations that appear well aligned around shared purpose and decision-making structures. These organizations are also working together to solidify their data and measurement, financing, and governance engagement strategies.

Third, our findings on perceived alignment levels across the four components suggest ways in which communities may proceed in aligning services. Given the relatively high alignment levels perceived by all three HUBs across purpose, data and measurement, and decision-making, we hypothesize that successful efforts to align purposes and data and measurement may increase confidence in decision-making across the organizations; this, in turn, may enable broader progress in aligning services for at-risk clients. Aligning processes to ensure sustainable finances and accountability, as well as long-term engagement in governance, appears more challenging and may require greater and continuing efforts over time.

Finally, our findings suggest that multiple factors drive alignment progress, and that at least some of these factors may influence progress across all four components. Even so, specific factors may be important for driving progress for a particular alignment component; this appears to have occurred in at least one case, in which ACA requirements encouraged hospital engagement in HUB governance. Still, while some driving factors are reported to have varied across communities and alignment components, others — leadership, trust, past failure to address a problem, and external funding requirements — appear to have supported alignment in all three communities across all four components.

While our findings provide insights on how communities use the PCH model to align organizational efforts across sectors, they are subject to limitations. We investigated only three communities, and our information sources were limited. Our data may also be subject to reporting

bias. Future studies could investigate a larger number of communities in additional states and could expand interviews (and other data collection) across a greater number of partners. They might also seek to further define and measure ways in which alignment processes result in improved outcomes, including confirmed reductions of client risks.

Overall, however, our analyses suggest that PCHI certification standards and PCH practices within communities are guiding cross-sector alignment processes, and that these processes are producing quantifiable benefits in the communities served. While our findings are best viewed as preliminary, they suggest that further use and study of the PCH model may prove beneficial in addressing the need to both facilitate and understand alignment progress and the associated outcomes in states and communities across the United States.

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COMMUNITY-LED COLLABORATION TO ADVANCE HEALTH EQUITY:
HIGHLAND SHOWS UP, SPEAKS UP, STEPS UP





Rachel Rosner
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Located just outside the urban hub of Charlotte, N.C., the city of Gastonia was for generations the home of a prominent and thriving textile industry. Over the past few decades, however, textile jobs have been sent abroad, and Charlotte has grown dramatically. In Gastonia, the Highland neighborhood felt the brunt of both the industry losses and the encroaching development.

In 2015, Healthier Highland, a unique collaborative of key partners across sectors and organizations, came together to develop initiatives to advance health equity and foster a healthier community. What made the collaboration extraordinary was its commitment to strong community engagement and resident-driven decision-making.

Healthier Highland's approach was to work across sectors to impact systemic barriers and upstream factors contributing to poor health conditions and outcomes. It devised an action plan to:

- Build a culture of healthy eating and active living;
- Foster community engagement;
- Reinforce networks of social support;
- Support clinical changes within the health center;
- Shape community development projects;
- Elect and appoint residents to leadership positions; and
- Secure financial and in-kind support for partnership work.

Our evaluative investigation of sustained multisector collaboration seeks to capture Healthier Highland's accomplishments and learning, focusing on how authentic community engagement is essential to collaborative efforts seeking to impact systems to reduce health disparities.

¹The neighborhood has a total population of 5,040 residents and is located in the 28052 ZIP code (more specifically, in Census tracts 319 and 320). All U.S. Census data is from the American Fact Finder, *American Community Survey 5-Year Estimates 2013–2017* at <https://data.census.gov/cedsci/advanced>

THE HIGHLAND NEIGHBORHOOD

Highland’s residents face higher rates of economic instability, health issues, and adverse social and environmental factors than residents in other areas of Gaston County. Table 1 shows Highland’s high rates of poverty and unemployment, as well as its low wealth, illustrating the disparities when compared to a neighboring ZIP code and Gaston County as a whole.¹

Table 1. Highland Neighborhood Equity Metrics

| METRIC | HIGHLAND NEIGHBORHOOD (CENSUS TRACTS 319 AND 320) | 28052 (HIGHLAND ZIP CODE) | 28056 (NEIGHBORING ZIP CODE) | GASTON COUNTY |
|--|---|---------------------------|------------------------------|---------------|
| People living below 100% federal poverty | 38.4% | 26.5% | 11.9% | 16.1% |
| People living below 200% federal poverty | 65.5% | 55.9% | 28.1% | 40.8% |
| Median household income | \$18,447 | \$49,850 | \$84,462 | \$46,626 |
| Unemployment rate | 19.8% | 9.8% | 5.0% | 5.9% |
| Renter-occupied housing | 69.0% | 55.3% | 21.1% | 34.0% |
| Average value of owner-occupied home | \$61,150 | \$96,600 | \$164,400 | \$126,000 |

In 2014, a group of leaders from Kintegra Health–FQHC, Gaston County Department of Health and Human Services Public Health Division, the city of Gastonia, CaroMont Health, NC Cooperative Extension–Gaston County, and HealthNet Gaston came together to address these health disparities. By 2015, they were awarded a grant to deepen this work using the Community-Centered Health (CCH) model. The emerging group organized the neighborhood residents, who would later form the Highland Neighborhood Association and be a key collaborative partner. The collaborative’s primary goal was to improve community health by designing and implementing strategies based on community-identified priorities and engagement.

The new effort, which fully launched in 2016, would become known as Healthier (or Healthy) Highland. One of the collaborative's first steps was to hire a well-respected community leader to serve as the coordinator to immediately engage neighborhood residents and allied partners. With community engagement at its core, the collaborative identified obesity as the priority health condition to address. The collaborative took a comprehensive, systems approach to impacting community health, with a focus on improving residents' body mass index, which can contribute to improvements in diabetes and hypertension.

METHOD: THE FRAMEWORK AND PROCESS

Our summative evaluation explored the process and outcomes of Healthier Highland's community engagement and its impact on cross-sector collaboration for improving community health. We grounded the evaluation in health equity based on social determinants of health (SDoH) — including power imbalances and historical legacies driving health outcomes and inequities — and assumed that individuals and communities are experts in their own experiences.

We had three overarching learning questions:

1. What was most important for centering and sustaining community engagement?
2. What were the best strategies and structures for forming and building cross-sector collaboration?
3. What is needed to sustain this collaborative work?

The evaluation framework consisted of three domains or levels of change: individual, collaborative/organizational, and community. Here, we focus on the collaborative domain, but the three levels had significant intersections (see Appendix C for more on engagement metrics). Our evaluation surfaced a variety of process metrics that indicate shifts in practices, including shared decision-making and garnering resources for neighborhood infrastructure.

The collaborative's participatory approach was modeled in the evaluation process by forming an evaluation committee that met monthly to cocreate the project. The committee agreed

on definitions, designed the learning questions and evaluation tools, identified populations for the focus groups and interviews, and provided input on the preliminary and final findings. The qualitative methods for data collection included the following:

- A review of existing materials;
- Resident focus groups (one with young adults and one with representatives of the collaborative);
- 12 interviews with leaders within and outside of the collaborative (see Appendix B); and
- Ongoing meetings with the evaluation committee.

From these, we gleaned the initial thematic results and shared them with the evaluation committee to validate and identify any significant gaps. Based on their feedback, we conducted additional interviews to address those gaps.

FINDINGS: LEARNING FOR CROSS-SECTOR COLLABORATION AND COMMUNITY ENGAGEMENT

Our findings capture the experiences and perspectives of the interviewees, focus groups, and evaluation committee; together they provide collective results of the community-based collaborative's accomplishments and learning.

We identified internal and external factors that contributed to effective community engagement. Here, based on our learning questions, we organize the results according to three areas of findings:

1. Relationship building as foundational to fostering trust and collaboration;
2. Community-centered practices, structures, and strategies that support authentic engagement; and
3. Success factors for sustainability.

Foundation of Trust and Relationship Building

To understand the extent of Healthier Highland’s accomplishments, it is important to understand the lived experiences of the neighborhood and its residents. When asked about their neighborhood’s assets and challenges, interviewees identified the main community asset as the depth of community connection and neighborhood pride.

The pride and passion people have in the community, for generations, it amazes me. — Interviewee

The number-one barrier to people thriving in Highland? Racism. — Community leader

One of the primary challenges identified was a deeply embedded history of systemic racism. Other top challenges cited point to SDoH and inequity, including access to healthy food, economic opportunity, access to affordable health care, and mental health issues.² Historically, there has been a lack of investment in the community, a lack of continuity with health care providers, and a lack of voice in local decision-making. These external factors created mistrust among residents in local institutions and their leaders; residents viewed them as being disconnected from the community members’ real needs and as moving forward with projects without consulting the people most impacted.

The Highland community had very little voice in city governance, and political power has traditionally been held outside the neighborhood. Furthermore, there is a tension between the Gastonia City Council, which has become more racially diverse and progressive, and the highly conservative, all-white Gaston County Commission. Within the collaborative, trust and relationships were built by consistently listening to and showing up for each other in collaborative spaces, investing in and hiring local leadership, and having accountability to community-voiced

² Additional (second-tier) challenges facing the neighborhood that respondents mentioned include chronic health conditions, such as obesity; lack of affordable housing; the fact that many people are in survival mode; and the pressures of gentrification. It is notable that the primary issues are underlying contributors to some of the secondary issues.

priorities. According to one interviewee, a “stroke of accidental genius” was when the collaborative sent a group of community members and Gastonia’s community development director to a health conference; once there, they built relationships, shared their organizational goals, and broke bread with each other over several days.

When you’re able to see somebody’s heart, then you know you can trust them. And that has meant everything to me. That’s what I try to do is really show people my heart and be open and honest and transparent and vulnerable. — Vincent Wong, community development director, city of Gastonia

More trust was built over time as the community saw key partners consistently participating in the collaborative’s meetings, learning about their history, listening to their interests and needs, and engaging in difficult conversations. As community members experienced their voices being heard and answered with action, they began attending and speaking at city council meetings and public hearings. As the collaborative cultivated these relationships and built greater trust, it led to a more mutually beneficial relationship between the city and the community; the result was that more than \$1 million of city investments were more intentionally aligned with the community’s priorities.

The partnership and relationships established through CCH have opened up opportunities to engage in many different capacities. ... As opposed to city staff making decisions about the allocation of resources in Highland, staff now depend upon the neighbors of Highland and the Healthier Highland partners to help guide their work in the community. — Grant proposal

In the past we didn’t know about decisions, we were notified later, after the project and decisions were made. Now people want to come to our table. — Trevolia Hill, evaluation committee member

Community-Centered Practices, Structure, and Strategies

Healthier Highland centered community in all of its practices, structures, and strategies, beginning with a shift from being organization-driven to being community-driven. Initially,

participating organizations and agencies were accustomed to designing and driving agendas. The community-centered health model was based in the belief that patients and their families are the experts in understanding their needs and barriers to improved health. However, the shift to being community-driven was not immediately accepted universally; according to one interviewee, “there was some skepticism about their ability to succeed.” Some individuals and groups with more positional power stepped back because they were unaccustomed to following rather than leading. For example, hospital leaders participated less in the collaborative as they struggled to find their role in the community-centered and community-driven approach. And as they stepped back, space was opened up for other actors to grow into leadership roles.

When we started, it wasn’t clear that the medical organizations had a relationship with the neighborhood, or how residents would be included. Health care was not connected with the community. — Interviewee

One of the collaborative’s fundamental strategies for growing community involvement was to first talk with residents about their concerns and priorities before making decisions that affected the neighborhood. This continues to be a standard practice of the collaborative to this day. One of Healthier Highland’s first events was hosting a “family reunion” that brought the neighborhood together for a social event with food and fun activities. Families were invited to take a survey about their interests while their children played games, and health information and screenings were provided. Building on the strong African American family reunion tradition proved to be very effective in engaging the community and hearing from residents, and the reunion continues to be a favorite annual event.

Talking with the community first, asking what they think, creates more buy-in and guides the whole process. — Abby Newton, special projects manager, Gaston Department of Public Health

³ The four committees are Clinical Shift to Support Community Centered Health, Community/Environmental Policy Change, Increase Community Capacity and Sustainability, and Strategic Communications.

Those who are the most impacted by the work should come first and have the loudest voice and be part of the decision-making process. — Donyel Barber, project coordinator and Gastonia City Council member

Forming a community-based leadership and structure were also fundamental to successful engagement and trust building. Community-determined goals were the centerpiece from which the collaborative formed four committees — each focusing on a specific priority area — to encourage deeper participation and opportunities for leadership.³ Having shared leadership encouraged and enabled connection and shared purpose, and contributed to greater alignment between collaborative partners and their respective sectors. The collaborative also used these community-determined goals to guide and leverage public and partner resources. The youth garden exemplifies how community-centered collaboration facilitates engagement while also fostering cross-sector strategies. The garden was founded to organize and educate young people and their families and to foster a closer relationship to the land and food they consume. It also encouraged ownership of a place-based project and increased access to healthier foods. By leveraging its relationships and resources, the collaborative was able to move the project forward quickly — from idea to garden in just two years. The city donated the land, while its Department of Health and Human Services contributed supplies, Agricultural Extension shared essential expertise on gardening, and Healthier Highland provided additional leadership and professional development for the youth.

By centering the community, the traditional balance of power shifted in the collaborative and eventually impacted other institutions and systems. The Highland neighborhood and the surrounding city of Gastonia have seen their governing and advisory bodies become more inclusive in composition and practice. Collaborative members helped to elect two city council members (the Healthier Highland coordinator, who became the first African American woman elected to the Gastonia City Council, and another collaborative member) and an African American mayor — all from the Highland community. Additionally, four members of the Highland community now serve on city and county advisory committees.

Success Factors for Sustainability

The collaborative is highly invested in the community's future and in sustaining its organizing efforts. Collaborative members understand that immediate needs must be addressed, while also looking at the long-term conditions to envision what comes next. The external factors of employment, development, and gentrification will continue to impact the neighborhood and the well-being of its residents. The collaborative leaders are tuned in to these changes and, as the collaborative coordinator notes, “we need to be integral parts of the balanced growth” rather than the victims of displacement.

An example of forward-looking strategies and innovation is the collaborative's development of a neighborhood-based catering/food enterprise. With food insecurity still a pressing issue and no immediate plans for a local grocery store, the collaborative decided to leverage community resources and build locally. The food enterprise will provide affordable access to healthy meals, while also creating economic opportunities through an entrepreneurial business model. At the writing of this report, the collaborative had hired a local caterer from the community to coordinate the enterprise. The ultimate goal is to consistently provide low-cost, healthy foods that have been taste tested and approved by residents — again making the community the center of innovation development.

**[Younger adults] want to see real, tangible things and engage them to do things, not only about eating habits, [but also] a new job or business venture.
— Young adult focus group participant**

One of the most pressing sustainability issues interviewees noted was the need to continually expand the collaborative table to include those who are not yet engaged. The Latino community has been identified as a key and growing constituency that is missing from the collaborative. The collaborative identified language accessibility as a critical component to reaching this community and churches as an important partner for outreach. The collaborative has existing relationships with local churches through its food distribution and food enterprise efforts, and members see this as an opportunity to deepen those relationships and expand their cross-sector collaboration.

The collaborative has also recognized the imperative to engage more youth and young adults. Interviewees said that factors to engage youth must include showing up consistently and adapting to their interests, which may change frequently. Collaborating more with schools was noted as a strategy for bringing in younger families, as was connecting those families to opportunities in the community (such as the youth garden and food enterprise). Political education and civic engagement were seen as other ways to meet the interests of the neighborhood youth who had mobilized in response to the 2020 racial justice protests. Finally, communication through various social media platforms was seen as essential for youth outreach, as many respondents expressed a need to strengthen and tailor communications to reach a range of age groups.

DISCUSSION: COMMUNITY ENGAGEMENT MAKING A DIFFERENCE IN HEALTH EQUITY

Healthier Highland’s community engagement experiences can be useful to other collaborative efforts seeking cross-sector alignment for advancing community health. The collaborative chose obesity as a priority not only because of the high rates, but also because of the underlying root causes of lack of investment in the neighborhood and other inequities. To be effective, a health equity orientation must be matched with accessible and culturally relevant practices and opportunities.

**If the model is formed correctly, it could be applied anywhere.
— Marcus Cyprian, Agricultural Extension**

Healthier Highland demonstrates how centering the community can set a different path for improving the health of those most heavily impacted. This means investing time and energy into building trusting relationships and shared purpose, consulting with community first, being driven by community priorities and engagement, having representative leadership that employs inclusive organizing and decision-making processes, and directly addressing historical and systemic racism.

[Healthier Highland] created a powerful bridge with community. They could discuss race, income, history, and the systemic causes of poor health. — Rich Bell, technical assistance provider

I would say in a lot of ways the collaborative has transcended the boundaries of individual organizations to become one entity with a shared purpose and focus. — Donna Elliott, HealthNet Gaston

When asked what message they would like people to take away from this study, the evaluation committee said that “with community engagement and commitment, we gain our voice and power to make changes” and that community voice can make a difference. Sustained community engagement got the attention of the health care providers, civil servants, elected leaders, philanthropic partners, and others. Collaborative partners and community members could see results, which helps to improve accountability and confidence in systems. Among many examples, they saw how a youth garden can address community priorities through cross-sectoral programming and how residents can have a greater voice by being invited to advisory groups or being part of an effort to successfully elect their neighbors to the city council.

You come to realize that you do have voice, a chair, [and] have to have the vision for people to join. — Collaborative focus group participant

The Kintegra Health Center data in Table 2 shows changes in health-related results between 2016, when the collaborative started, and 2019. The percentage of patients with diabetes and hypertension dropped in just three years — a short time for changes in chronic disease. Use of the emergency department also dropped significantly during this time, which may reflect the reduced severity of health conditions in the neighborhood. These changes cannot be fully attributed to Healthier Highland; however, the results occurred within the context of a concerted collaboration with significant attention to community engagement. In a community that has experienced extreme health disparities, these indicators of improved health outcomes and rates of health care utilization are promising.

Table 2. Health Metrics for Kintegra Health Center

| METRIC | 2016 HIGHLAND NEIGHBORHOOD | 2016 GASTON COUNTY | 2019 HIGHLAND NEIGHBORHOOD | 2019 GASTON COUNTY | HIGHLAND % CHANGE 2016-2019 |
|---|----------------------------------|--------------------------|----------------------------------|--------------------------|-----------------------------------|
| Patients with diabetes | 9.30% | 6.00% | 6.23% | 5.88% | -33.01% (-3.07%) |
| Patients with hypertension | 20.20% | 10.90% | 15.50% | 9.29% | -23.27% (-4.07%) |
| Average monthly Medicaid cost | \$862.51 | \$454.43 | \$843.65 | \$390.29 | -2.2% (-\$18.86) |
| Emergency department visits/100 Medicaid patients | 119.1 | 71.8 | 80.4 | 56.4 | -32.5% (-38.7) |

Source: Kintegra Health

While our study looked back to capture success factors and challenges, Healthier Highland is looking to the future. The now-established collaborative provides the infrastructure needed to bring community voice into the region's complex debates and influential decisions. Healthier Highland and its members are continually showing up to voice their concerns, speaking up to contribute to community-based solutions, and stepping up into positions of leadership. In the four years since it formally came together, Healthier Highland has modeled how a commitment to community engagement can be the north star for healthier communities.

APPENDIX A: EVALUATION OBJECTIVES AND LEARNING QUESTIONS

Evaluation Project Objectives

- To lift up community voices and perspectives when assessing the current state of Healthier Highland’s engagement processes and results
- To identify the contributing factors that supported community engagement and alignment within the collaborative
- Based on the findings, to share implications and recommendations for the field

Meta Evaluation Questions

- What was most important for centering and sustaining community engagement?
- What were the best strategies and structures for forming and building cross-sector collaboration?
- What is needed to sustain this collaborative work in relation to internal systems and culture, strategic financing, adaptability, community support, and so on?

Learning Questions

Asterisks indicate priority questions.

1. What went well? What were the strengths?*
2. What do we not do so well?*
3. What were the unexpected outcomes?

- A. How can we capture what other communities are doing after hearing about Highland?
4. What was most important for initiating and maintaining community engagement?*
- A. How do you get people involved, buy-in?
- B. Why get involved?
- C. How does communication get people involved?
- D. How to reach more people?
- E. What other things are in the toolbox?
5. Are the right people at the table?*
- A. Who is not at the table? Who is missing?
- B. How can more patients be involved?
- C. How can we involve people who are directly impacted by decisions?
- D. From the Healthier Highland collaborating partners perspectives: Are the right partners at the table? Who is not at the table, who's missing?
6. How to keep youth involved over time?*
- A. How can we get youth interested and keep them coming?
- B. How can we get more young people involved?
- C. How do we keep high school success going?
7. Based on what we have learned, what are the implications for the next phases of the work?

- A. How do we duplicate in other areas?
 - B. What's next for the group short- and long-term?
 - C. What is needed? And what do we need to be doing?
8. What were the best strategies and structures for forming and building the partnership? For centering authentic community engagement?
 9. What is needed to and how do we sustain this collaborative work, including internal systems and culture, strategic financing, adaptability, and community support?*
 10. In what ways has Healthy Highland been able to respond to the current and unexpected COVID-19 pandemic?

APPENDIX B: EVALUATION ACTIVITIES AND METHODS

To collect multiple perspectives, the evaluation process included a review of existing materials, focus groups of residents (one with young adults and one with representatives of the collaborative), 12 interviews with leaders within and outside the collaborative (see the list below), and ongoing meetings with the evaluation committee. From the initial findings, we gleaned thematic results to share with the evaluation committee to validate and identify any significant gaps.

Based on the committee's feedback, we conducted additional interviews as follows:

- Two focus groups (cofacilitated with residents; we had planned a third focus group with youth, but it was canceled due to COVID)
 - Young adults
 - Collaborative meeting

⁴ Pastor, M., It, J., & Rosner, R. (2011, October). *Transactions, transformations, translations: Metrics that matter for building, scaling and funding social movements*. University of Southern California Program for Environmental and Regional Equity. <https://dornsife.usc.edu/pere/metrics/>

- Two meetings of the collaborative and Highland Neighborhood Association (in December 2019 and December 2020)
- 12 interviews with internal and external leaders (via telephone)
- Eight evaluation committee conversations/meetings and observations
- Monthly check-in calls with the evaluation core team
- A planned survey of patients in the clinic (canceled due to COVID)
- We conducted interviews with 12 leaders within and outside the collaborative as follows:
 - Fred Williams, law enforcement (community policing): July 7, 2020
 - Dot Guthrie, school board and African-American Museum: July 17, 2020
 - Rev. Rodney B. Freeman, Mt. Zion Restoration Church: July 7, 2020
 - Tasha White, homeless advocate: July 6, 2020
 - Elveria Hoke, Kintegra, community health worker: August 14, 2020
 - Vincent Wong, city of Gastonia, director of community services: June 26, 2020
 - Marcus Cyprian, NC Cooperative Extension: June 26, 2020
 - Abby Newton, Gaston County Health Department: June 29, 2020
 - Donna Elliott, HealthNet Gaston: June 26, 2020
 - Rich Bell and Linda Kinney, TA providers: April 29, 2020

⁵Foster, C. C., & Louie, J. (2010, March). *Grassroots action and learning for social Change: Evaluating community organizing*. Blueprint Research & Design, Inc.

- Victoria Pendergrass, counselor, Woodhill School, July 24, 2020
- Ruth Dobbins, volunteer and founder of COVID Care, August 7, 2020

APPENDIX C: COMMUNITY ENGAGEMENT METRICS

We looked for three types of results; our goal was to name metrics that fully capture changes on the different levels, focusing on the collaborative level.⁴

Types of Metrics

- Transactions: Markers for change
- Developmental: Process of collaboration and alignment
- Transformational: Systems change (alignments and shifts in values, systems, behavior)

Individual

- Transactions: The go-to person for press, events, and resources
- Developmental: Shared leadership that is inclusive, and committee structure that centers community engagement and fosters capacity building
- Transformational: Trusted local leaders — such as the community resources advocate and the collaborative coordinator — that connect people to resources, anchor the work, and foster collaboration

Collaborative/Organizational

- Transactions: A critical mass of community leaders and groups with shared power analysis and ownership

- **Developmental:** Shared purpose and practices with programming that reflect the community's priority outcomes
- **Transformational:** Seeing the connections across sectors, supporting each other (public, private, nonprofit), and taking a holistic view of individual and community health

Community-Level Change

- **Transactions:** Large community turnout at culturally relevant events that are informative, social, and serve as a hook for further engagement (and have healthier foods as the standard)
- **Developmental:** Supporting leaders who represent the community to step into governance positions and advisory positions with power (elected city council members)
- **Transformational:** Community programming and infrastructure that allows for healthier learning and living (youth gardens, water fountains in schools, and bathrooms in parks)⁵

APPENDIX D: FUNDING SOURCES

- **The Lee Institute Community-Centered Health pilot:** In 2015, the collaborative received \$10,000 for work on Community-Centered Health core activities. It hosted focus groups with the community around the Community Health Needs Assessment to get feedback and then presented the findings back to participants and to other members of the community.
- **Blue Cross Blue Shield of North Carolina Foundation Community-Centered Health Grants:** The collaborative applied in August 2015; in early 2016, it was awarded \$125,000 for a one-year grant term (April 2016-March 2017). It then renewed its funding at the same level for April 2017-March 2018, April 2018-March 2019, and April 2019-March 2020.

- **de Beaumont Foundation BUILD grant, third cohort (2018 or 2019):** The de Beaumont Foundation partners with other foundations to award the BUILD Health Challenge; in North Carolina, the BlueCross BlueShield of North Carolina Foundation is the funding partner. Healthier Highland was awarded \$125,000 per year for two years in fall 2019, and \$75,000 per year from CaroMont Health, its hospital partner, for a total of \$200,000 per year for two years.
- **Z. Smith Reynolds Foundation (2019):** In 2019, Healthier Highland was awarded \$220,000 from the Z. Smith Reynolds Foundation over a two-year period: \$145,000 the first year, and \$75,000 the second year.



CHAPTER SEVEN

Two Years In: What We've Learned and
Where We Go From Here

Glenn Landers

Aligning Systems for Health was awarded to the Georgia Health Policy Center (GHPC) by the Robert Wood Johnson Foundation (RWJF) in May 2019 and was fully operational by June of the same year. The project’s primary purpose has been, and remains, to assist RWJF and the broader field of practitioners, catalyst organizations, other funders, and researchers to learn as much as possible about the concept of aligning and to move the field forward. GHPC approached this work in three ways:

- Awarding and managing a \$3 million portfolio of research grants;
- Synthesizing what is known across the existing literature and through partner practitioners of aligning (some funded by RWJF, others not); and
- Developing and gleaning emerging knowledge from practitioners, researchers, and partner organizations.

Our goal has always been to draw learning from both practice and research. In this chapter, we review the contributions of both streams of work and look ahead to what we see on the horizon as Aligning Systems for Health matures.

RESEARCH AWARDS

As of March 2021, Aligning Systems for Health has awarded seven large, two-year research grants and 12 smaller, rapid-cycle grants; we expect to award two additional rapid-cycle grants by late spring 2021. Chapter 6 details the first six rapid-cycle awards, each of which contributed to our shared learning and — as we discuss below — to a transition from the original Cross-Sector Alignment Theory of Change to a revised Framework for Aligning Sectors.

- JSI researchers suggest that purpose and governance are perhaps the most foundational of the theory of change’s core components, but that components can overlap. They also demonstrate the importance and challenge of building equity into the aligning process and how crucial it is to find good models for practitioners to accomplish this.

- Public Health Solutions researchers were forced to shift gears mid-research due to the COVID-19 pandemic; they found that a shared purpose must be translated into a clear and documented action plan and that during a crisis, partnerships between health care and the community are fragile and difficult to maintain.
- Urban Institute researchers explored the role of shared data systems among state government agencies. They found that strong governance can support data sharing and also that relationships and trust among parties are almost more important than the technology itself.
- Communities Joined in Action researchers surveyed a range of community-based collaboratives to explore how internal and external factors impact cross-sector partnership design, functionality, and sustainability. They found that interorganizational power dynamics are challenging to overcome and that the importance of policy is often overlooked as aligning systems concentrate on on-the-ground efforts. They also highlight the role of community voice in helping to build political support for change.
- Researchers from Akron Children’s Hospital and Kent State University demonstrated that the Pathways HUB model of care coordination is consistent with the theory of change components and serves as one model of how to implement aligning.
- Care Share Health Alliance/Healthier Highland researchers were the first to include community members in the research, and their work demonstrates that engaging community members in collaborative work requires focused outreach, organizing, and often, re-engagement over time.

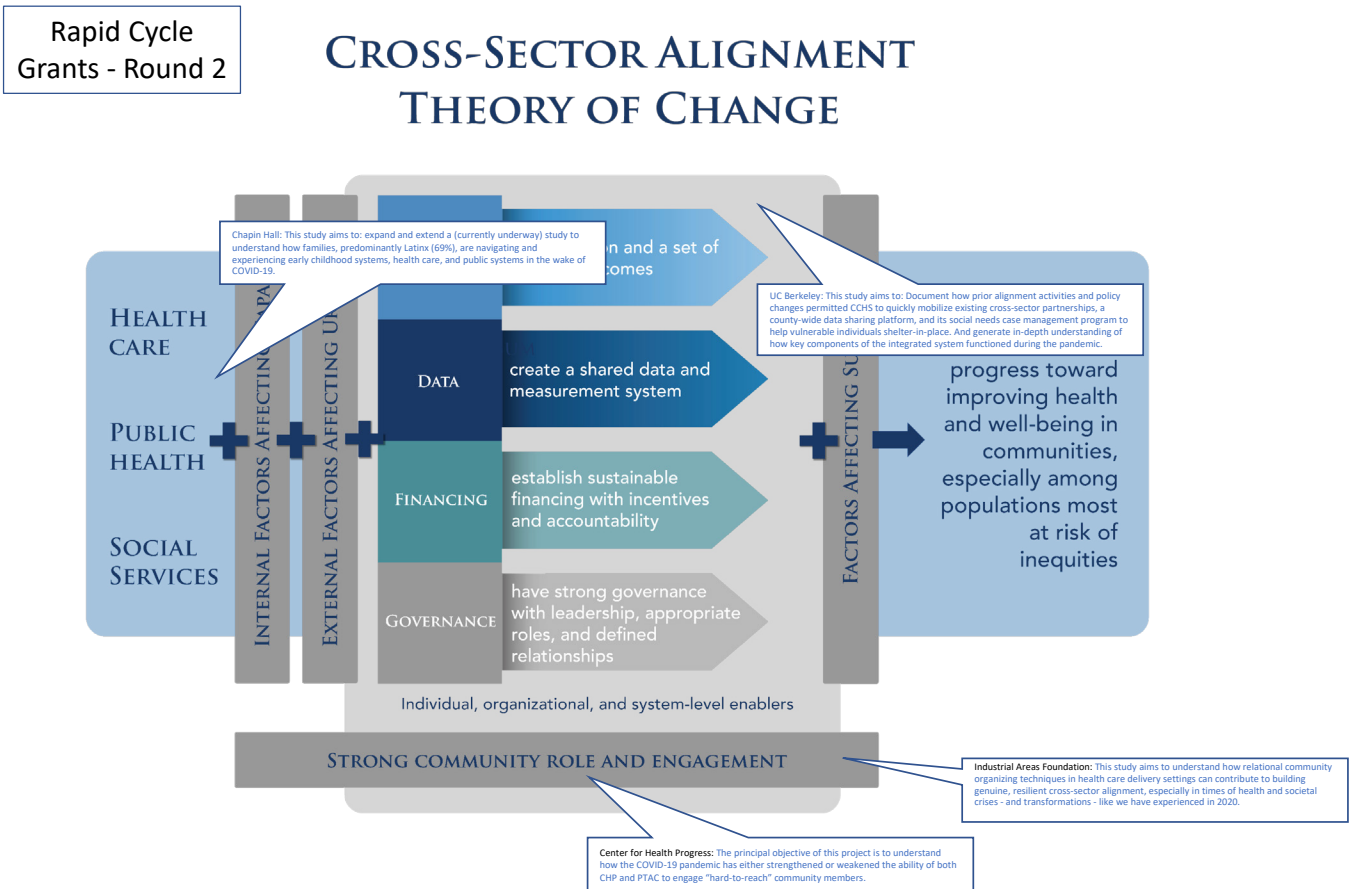
In November 2019, GHPC launched a nationwide call for proposals for larger research grants of up to two years. We awarded seven grants in May 2020, and we expect results in 2022. As with the first rapid-cycle grants, these larger grants explore aspects of the theory of change, but, as Figure 1 shows, they are more ambitious due to greater resources and time. For example, the research designs are more likely to include quantitative analysis and cross-site comparisons. We

public health, health care, and social service sectors in 22 Accountable Communities of/for Health (ACHs) in California and Washington.

- Researchers at Rush University Medical Center are assessing how well a health-equity collaborative of six hospitals has developed tools to address the four components of cross-sector alignment, as well as how the engagement of community voice has impacted development of the core components.
- University of Washington, Seattle, researchers are testing the relevance and applicability of the theory of change within American Indian and Alaska Native nations. The study will engage tribal stakeholders in practice-based research to identify and describe an emerging, complementary theory of change framework in tribal nations.
- Researchers at the University of South Carolina Columbia Center for Community Health Alignment are studying the Alliance for a Healthier South Carolina's collaborative efforts and community engagement in four communities. The evaluation will identify effective strategies that foster intentional, meaningful alignment with the communities most impacted by health inequities. It will include how to effectively build on the capacity of community health workers and community leaders to work alongside health care, public health, and social service sectors in the Cross-Sector Alignment model.
- Texas Health Institute researchers are conducting realist research of up to 24 cross-sector initiatives in Texas to test the theory of change in diverse population, geographic, and political contexts.
- Trenton Health Team researchers, in partnership with the Social Interventions Research and Evaluation Network, are identifying the individual, organizational, and systems-level barriers that prevent community-based organizations from fully participating in technology-based referral systems. Their goal is to design engagement strategies that may reduce those barriers and to test alternative strategies' effect on the participation of community-based organizations.

In March 2020, the COVID-19 pandemic became widespread in the United States. GHPC responded by directing four small research grants to study how COVID-19 was impacting aligning organizations and vice versa (see Figure 2). Our call for proposals enabled an even greater focus on including community members in the research. We will feature results from the following four projects in a future volume.

**Figure 2. Rapid-Cycle Research Grants (Round 2)
Mapped to the Theory of Change**



- The Center for Health Progress in Denver and the Pueblo Triple Aim Corp. are conducting descriptive research to assess efforts to better understand how the COVID-19 pandemic strengthened or weakened the ability of both organizations to engage hard-to-reach community members who have been historically and intentionally left out of traditional community-engagement processes.
- Researchers affiliated with the Industrial Areas Foundation Northwest are seeking to understand how relational community organizing techniques in health care delivery settings can contribute to building resilient cross-sector alignment.
- University of California Berkeley School of Public Health researchers are identifying how specific resources enabled by aligned systems are being used to reduce COVID-19–related risks, address barriers to sheltering in place, and overcome social and economic disruptions of virus-related closures for vulnerable patients in Contra Costa County.
- Researchers from Chapin Hall at the University of Chicago are examining how cross-sector alignment impacts the experiences of 120 diverse families with young children in California and Florida during the COVID-19 pandemic and economic crisis, including where systems struggle and succeed in responding to families’ needs.

RESEARCH SYNTHESIS

The research synthesis team’s main product was the literature examination in Chapter 2. Several findings influenced our refinement of the Framework for Aligning Sectors, including “the tension between action-orientation and patience, between striving for flexibility and seeking commitment, and between emphasizing structure versus leadership,” and the role of context in how much emphasis researchers placed on each core component. Another key learning from the review was how integral equity and community voice are at all points of aligning — not just at the destination — and equity’s relationship to community voice:

While many studies emphasize the importance of community voice, the literature has yet to elaborate best practices for prioritizing community voice. Establishing these practices will likely require changes in very large social and bureaucratic systems, but several collaboratives have demonstrated successes with bold initiatives that empower community voice.

BOTH EQUITY AND COMMUNITY VOICE SHOW UP AS DYNAMIC, ADAPTIVE FACTORS IN THE FRAMEWORK FOR ALIGNING SECTORS.

The synthesis team also generated several products — including three peer-reviewed papers — that have added to our understanding of aligning. “Equity from a Cross-Sector Alignment Perspective: Findings from a Literature Review” identified:

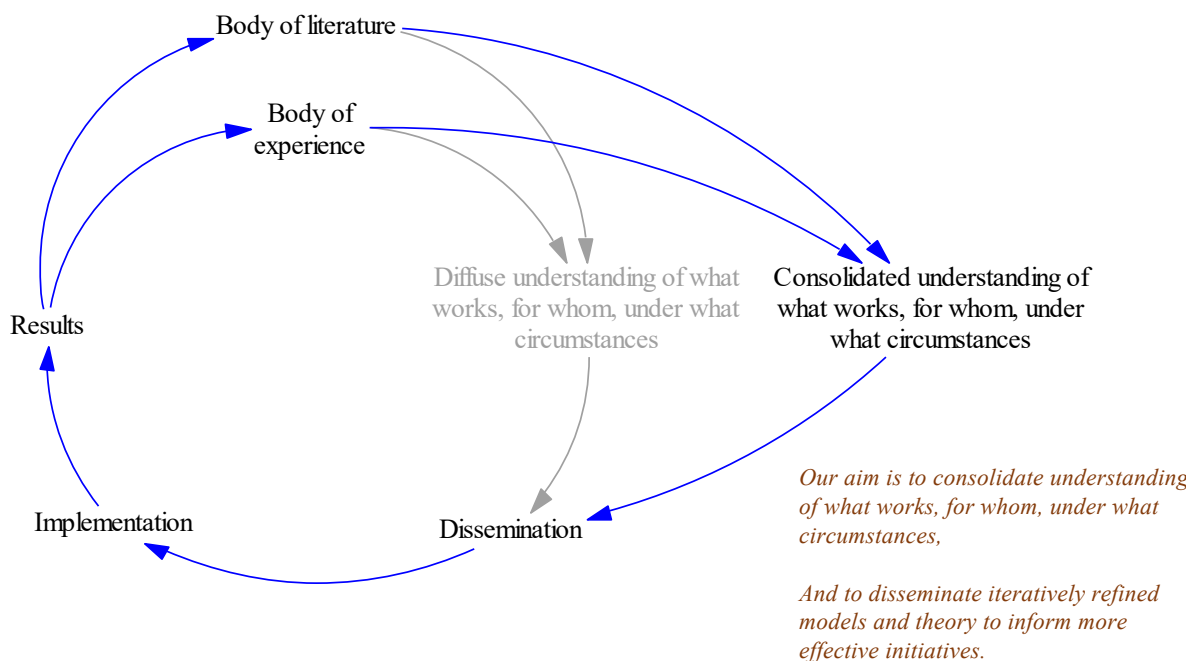
a number of barriers to increasing procedural equity and reducing health disparities and many strategies for overcoming them. These strategies can be implemented at the individual, organization, and systems level. As organizations transition from small-scale collaboratives toward systems-wide alignment, these strategies may help participants reduce or eliminate persistent health disparities.

In “Cross-Sector Alignment and the Response to COVID-19,” the team found that the theory of change is “a rich source of ideas for responding to the COVID crisis,” including meeting the needs for shared data, reexamining equity, and including community voice in decision-making. In “Community Voice in Cross-Sector Alignment: Concepts and Strategies from a Scoping Review of the Health Collaboration Literature: What Can We Learn from Research on Cross-Sector Alignment?” they found that engaging community voice in cross-sector collaboration can be active or passive and discovered “an association between sustainability orientation and the intensity of community voice engagement” that comes from more active engagement.

AN INCLUSIVE LEARNING SYSTEM

GHPC has developed a dynamic learning system that includes practitioners, catalyst organizations, funders, and researchers. The system envisions an interplay between the fields of research and practice. As Figure 3 shows, the idea is to create a consolidated understanding of what works, for whom, and under what circumstances, and to disseminate iteratively refined models and theory to inform more effective initiatives. The learning system pulls from both the body of experience — that is, real people doing real work on the ground to align sectors in real time — with the body of research literature.

Figure 3. The Aligning Systems for Health Learning System



This interplay has been achieved through various structured interactions with the four target audiences; the interactions include:

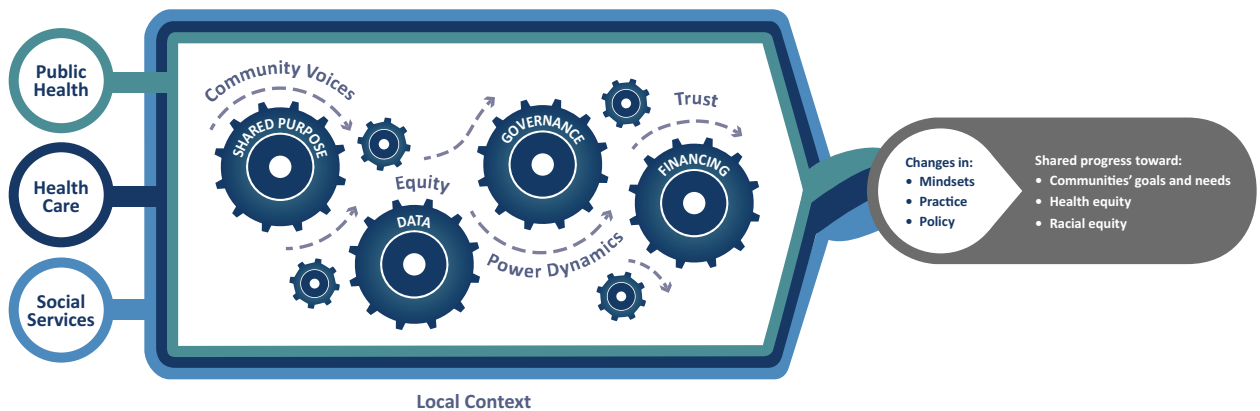
- A three-part online conference in spring 2020;
- Quarterly discussions with a national steering committee;
- Monthly convenings of RWJF aligning grantees to share knowledge;
- Multiple national webinars of research findings;
- A four-part speaker series exploring the adaptive factors within the Framework for Aligning Sectors; and
- Multiple interactions with RWJF leadership and staff.

In all, more than 3,000 individuals have interacted live with Aligning Systems for Health content in just over a year. The Aligning Systems for Health team members use each interaction as an opportunity to critically assess their thinking about aligning. Perhaps this is most apparent in how the core components of aligning sectors are now depicted as more dynamic — that is, we have found much greater overlap and interplay among the components than we first understood in May 2019.

A FRAMEWORK FOR ALIGNING SECTORS

In July and August 2020, the Aligning Systems for Health team reviewed and synthesized the previous year's learning about cross-sector alignment. Key documents, briefs, case studies, interviews, structured feedback, and other relevant data informed this first-round review of the theory of change. The review also included field input from a national charette conducted virtually in June 2020. The team found that stakeholders' on-the-ground experiences brought greater meaning and nuance to what they learned from the literature and research partners. As intended at the project's outset, the process of translating that learning led to our revising the theory of change, which culminated in its evolution to the Framework for Aligning Sectors (see Figure 4).

Figure 4. The Framework for Aligning Sectors



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With each iteration, the intention is for the framework to be more and more evidence-informed. Following are four key design changes.

The Core Components Remain Relevant

Our review confirmed that the framework's core components—shared purpose, governance, shared data and measurement, and financing—remain appropriate. What changed is how the dynamism and interdependency among the components are illustrated. At one point, for example, governance might be emphasized, while at other times, a project might focus intensely on shared data and measures.

Adaptive Factors Are Increasingly Recognized as Important

Synthesis and learning have highlighted four factors that are key to the successful implementation and sustainability of aligning sectors: community voices, trust, power dynamics (both between sectors and between the sectors and community members), and

the role of equity as a continual process rather than an endpoint. In the Framework for Aligning Sectors, these factors are integral to the function of the four core components.

Shared Progress Can Occur at Interim Points

Shared progress toward meeting communities' goals and needs, health equity, and racial equity does not happen quickly. First, there must be changes in mindsets, practices, and policies that support the more distal outcomes. These changes are thus essential short-term goals.

The Sectors Remain Distinct

As the new framework illustrates, the sectors — public health, health care, and social services — remain distinct. They do not integrate, but rather align in new and different ways that are accountable to the goals and needs of the individuals and communities they serve.

LOOKING AHEAD

As Aligning Systems for Health begins its third year, we are using the Framework for Aligning Sectors to guide our research, synthesis, and learning system. This is already evident in the framework's adoption and inclusion in other RWJF programs in the aligning space. In the near term, our team has turned to understanding how to measure the concept of aligning and its components, and how sectors might be held more accountable to the communities they serve.

Already, our team has produced the paper, “Existing Measures: Anticipating a Cross-Sector Alignment Measurement System,” which examines standardized and situational metrics, the development of measures over time, measurement levels, qualifiers that span concepts, and the measurement process. We also published “A Selection of Health-Oriented Collaboration Measurement Frameworks: Elements for Consideration in a Cross-Sector Alignment Measurement System,” which selectively reviews various health collaboration measurement frameworks to identify useful elements for inclusion in the framework. Our internal goal is to produce a draft measurement framework that is detailed enough to serve as the basis of an additional round of research grants.

To support the development of a measurement system, GHPC launched a third call for proposals in November 2020 for rapid-cycle research awards aimed at measuring aligning concepts. The results from these research projects will support the synthesis team’s ongoing work in developing a measurement system.

Over the longer term, deeper dives into understanding the adaptive factors of aligning sectors will certainly be a part of our work. As the field builds, there is a growing desire for guidance on how sectors can align to better meet the goals and needs of the communities they serve. GHPC is positioning itself to play a leading role in producing that guidance — driven by evidence, rigorous research, and the input of those most impacted by systems change.

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