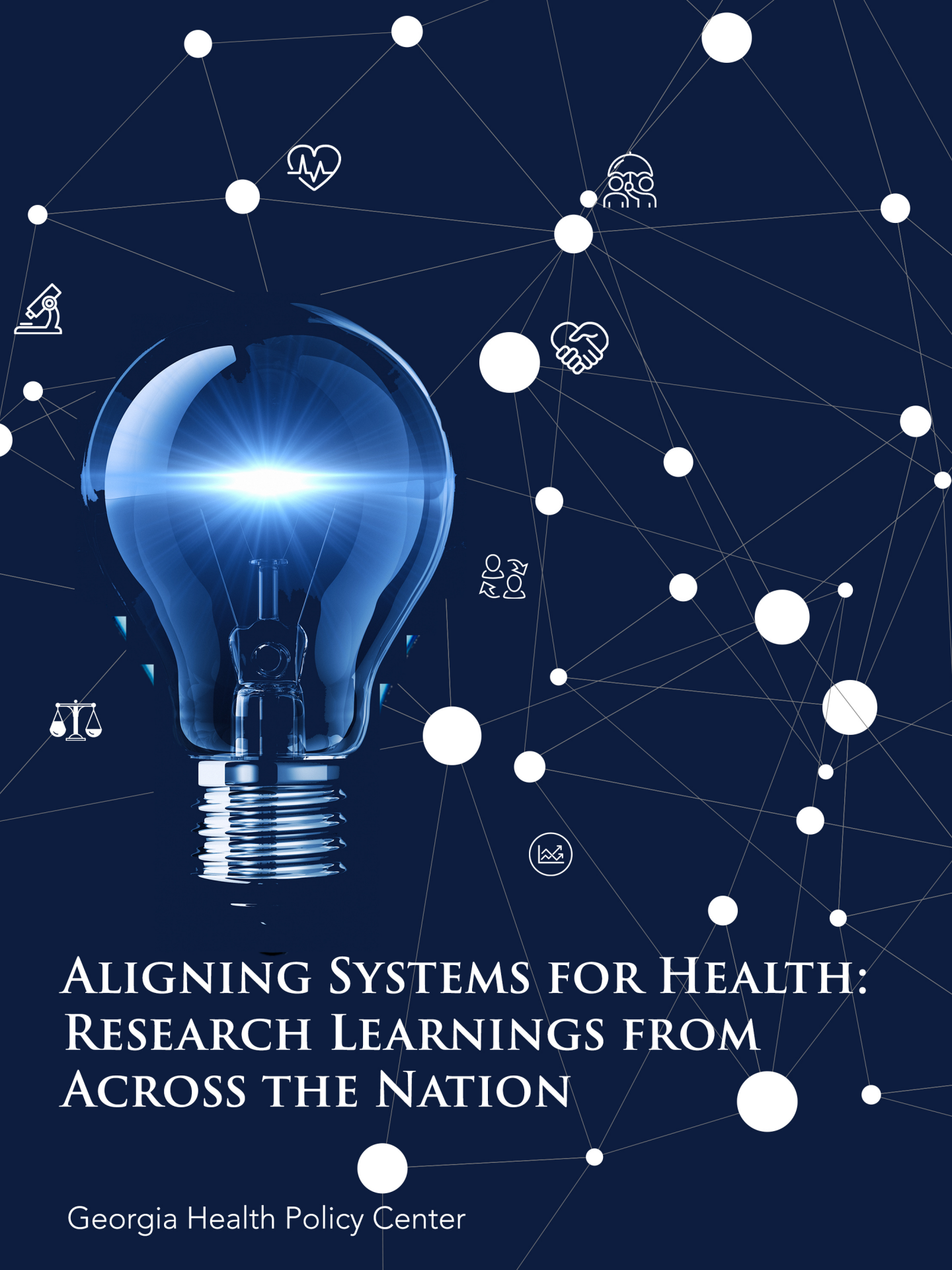
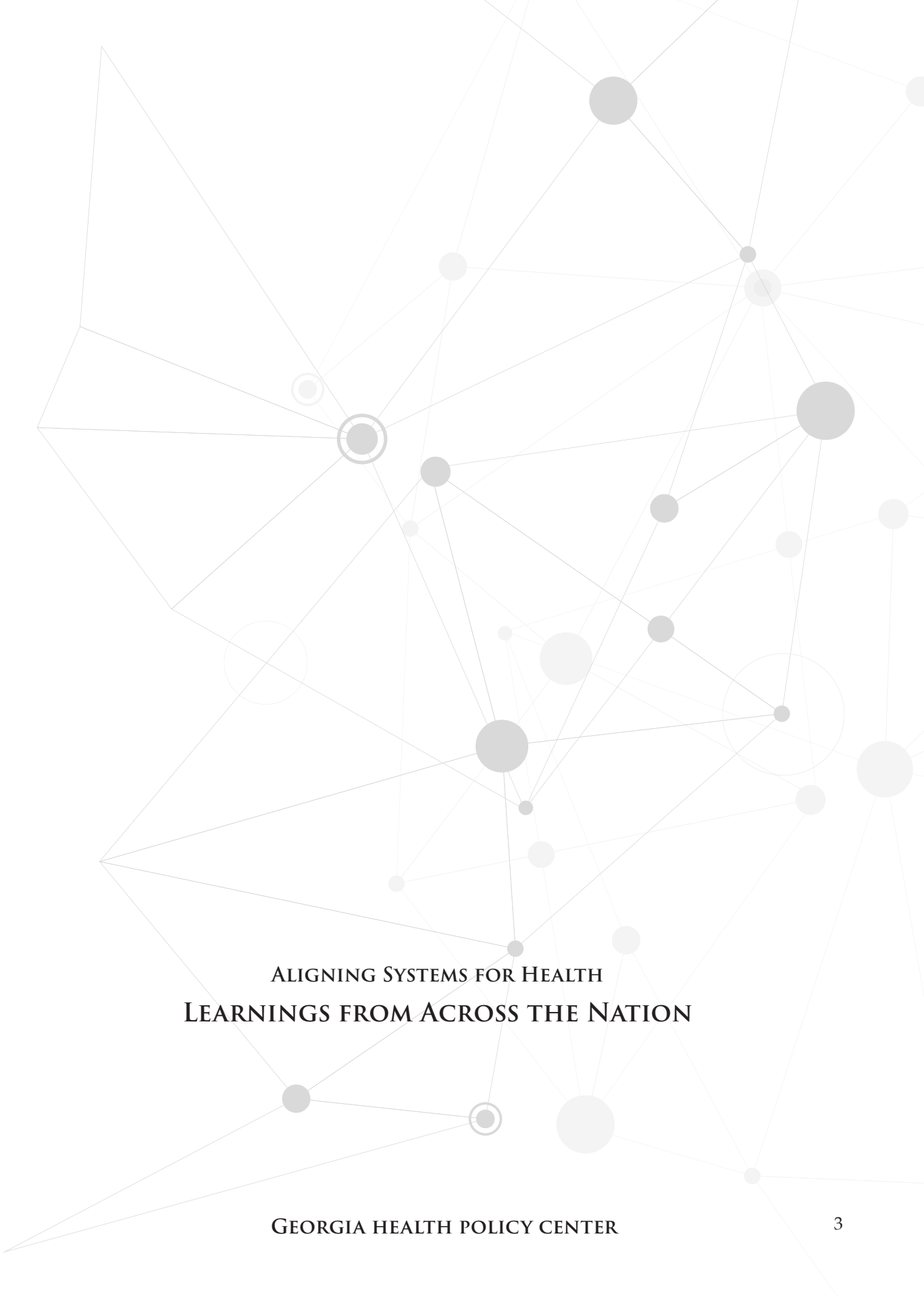


Aligning Systems for Health: Research Learnings from Across the Nation

Georgia Health Policy Center



Aligning Systems for Health

Learnings from Across the Nation

Aligning Systems for Health: Learnings from Across the Nation

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We dedicate this book to

Glenn Landers, a researcher, operations extraordinaire, relationship builder, trusted thought partner, and valued leader.

For nearly 25 years, Glenn was a model of the values of stewardship at the Georgia Health Policy Center and he worked tirelessly to advance the field of public health and impact the lives of Georgians and people around the country.

His legacy as a connector of knowledge, translator of complexity, and mentor to all will continue to inspire the work of Aligning Systems for Health and the staff of the Georgia Health Policy Center.

Glenn embodied the core pillars of aligning systems by aligning people and purpose, building trusted relationships, and committing to learning and making things better.

He will be missed as a colleague, collaborator, and mentor.

Glenn Martin Landers, Sc.D.
1963-2023

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Much like the work of aligning in communities, Aligning Systems for Health relies upon extensive collaboration with communities, researchers, catalysts, and advisers from across the country. You will read the learnings of research conducted by 14 organizations from around the country. We are grateful for each of these researchers' contributions to the field, to Aligning Systems, and to this book.

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Preface

Aligning Systems for Health began funding its first research cohort months before the onset of COVID-19. Throughout the pandemic, 21 research teams across the United States soldiered through the crisis trying to meet their organizational and community needs, while simultaneously trying to learn more about how the health care, public health, and social service sectors can work together to meet the goals and needs of people in communities.

As I examined the findings of these research studies, I was both amazed by and appreciative of the work, adaptability, and perseverance of these researchers and their partners in communities. The learnings — both those codified in this book and those that persist through the experiences of the researchers and partners — advance our understanding of how shared vision, governance, data, and financing are intertwined. And just as importantly, we also see how trust, power dynamics, equity, and community voice contribute to the evolution of mindsets, policies, and practices that are needed for everybody to thrive in all communities across the nation.

While the research questions and community contexts varied across these projects, three notable themes stood out to me across the studies: the importance of community voice, the challenges in the pursuit of equity, and the power of money.

Aligning to Respond to Crisis
Center for Health Progress
Chapin Hall
Industrial Areas Foundation
University of California, Berkeley

Measuring Aligning
Camden Coalition
JSI Research and Training Institute
Kent State
Public Helath Institute

Adopting Aligning Approaches
Public Health Institute
Texas Health Institute
Trenton Health Team
University of Lousiville
University of South Carolina
University of Washington
West Side United

The Importance of Community Voice

Echoing the sentiment of disability rights activist James Charlton's famous saying, "nothing about us without us," it is impossible to meet the goals and needs of communities without listening to the voices of the people who are most affected by the lack of opportunity to achieve health and well-being. Research shared in this book overwhelmingly acknowledges the need to engage with and listen to communities. The work of Public Health Institute, West Side United, and JSI Research & Training Institute provide innovative ways to listen to the voices and experiences of community members. The Texas Health Institute reminds us that lived experience is a central and valuable data source. University of South Carolina researchers stress the importance of acknowledging the history of previous work in communities, even if unsuccessful, and the importance of hearing past concerns to move toward building trusting relationships that can guide future community transformation work.

In many places, community members have no history — or no positive experience — of being included in community-transformation efforts. Organizations and cross-sector collaboratives need to be open, patient, and skilled in order to effectively center community voice. University of South Carolina researchers find that working with communities is a competence that many organizations and collaboratives must build. Chapin Hall researchers provide a possible structure for such community engagement.

In addition to having the internal mindset and skills to work with communities, organizations and funders should be prepared to support community members entering into these partnerships as full-fledged participants and decision-makers. The Industrial Areas Foundation reinforces that building skills is a critical part of power sharing, and University of Louisville researchers report that onboarding processes should be flexible and allow the time for building skills among community partners.

While current practice and evidence offer evolving guidance on which strategies are most effective for sustainably engaging community residents, it is important to note that support is needed bidirectionally — both for institutions to understand how to work with communities and for residents to have the capacity to participate in building connections and making their voices heard as decision-makers.

The Challenges of the Pursuit of Equity

Universally in this book you will find explicit acknowledgement of the desire for and the commitment to prioritizing health equity. Yet there is little consensus on how to achieve health equity or the tangible steps collaborative partners should take to meaningfully advance progress. Recognizing this need for concrete action, JSI identifies six pillars to operationalizing equity but warns that it is a resource-intensive process that requires both time and stable funding.

While the measurement of equitable outcomes at the population level seems rather straightforward, findings from cohort 3, which was heavily focused on measuring aligning, emphasize the challenges of measuring equity, particularly when shorter-term or proximal measurement of progress is desired.

Measurement of equity is complicated by a number of factors beyond the lack of a shared definition of equity. The Camden Coalition calls out the multidimensional and highly personal nature of (nonfinancial) value, including the personal value derived from engaging and participating in cross-sector collaboratives. The Public Health Institute finds how lived experience shapes perception of outcomes (e.g., equitable processes) and further, how the elements of the Framework for Aligning Sectors (e.g., equity and power sharing) are perceived as intertwined and difficult to distinctly measure. Taken together, much of the measurement-focused research captured in this book challenges us to think further about how individual and sector-related values and perceptions are reflected in the development of methods to measure equity and aligning more broadly.

The Power of Money

Traditionally, the players at the table with the most money had the most influence. But when examining the roles within collaboratives in the era of equity and through the lens of elevating community voice, one quickly realizes that shifting power is an imperative step in creating transformative change and power must be disassociated from the financial resources one brings to the table.

Truly aligning across sectors and with communities is a long-term and bidirectional undertaking, as opposed to one-time, grant-funded opportunities. Yet a perpetual challenge collaboratives face is obtaining the flexible funding needed that will allow participants to do the time-intensive, yet foundational, work of building relationships and trust.

Funders have an opportunity to positively influence the process of aligning across sectors and raising community voice through the length of funding and to whom funding is provided. Findings from West Side United, the University of South Carolina, and the Texas Health Institute all highlight the importance of flexible funding and longer funding timelines on permitting the space for relationship building. The luxury of stable, independent funding diversifies the participants in a collaborative and, according to West Side United and Communities Joined in Action, can level the playing field of influence by enhancing the ability of both community members and less-resourced community-based organizations to participate. In turn, Care Share recognizes that expanding engagement is a crucial aspect to collaborative sustainability.

A Legacy of Learning

As excited as I am to dive deeper into the research findings, I would be remiss if I did not acknowledge that all of this research was supported by the Robert Wood Johnson Foundation, and it builds on the foundation's decades of previous experience. That experience was detailed by foundation project officers and researchers in a history map that intertwined macro trends and federal policy (e.g., the Institute of Medicine's 2002 Unequal Treatment report and the passage of the Affordable Care Act in 2010) and foundation-specific milestones (funding the Camden Coalition in 2011 and establishing the core principles for a Culture of Health in 2014) to better understand the movement toward aligning across sectors. Hilary Heishman, the project officer for Aligning Systems for Health, assimilated those learnings to inform the first aligning theory of change, which served as an important starting point both for the researchers at the Georgia Health Policy Center and for the first cohort of research that was commissioned for the Aligning initiative. Over the next several years we reviewed the literature and co-learned with foundation staff, researchers at the Georgia Health Policy Center and across the country, and practitioners working in and with communities to produce the Framework for Aligning Sectors,

which advanced the thinking of the original theory of change to better reflect the centrality of the adaptive factors — community voice, power dynamics, trust, and equity — in the practice of aligning across sectors.

I also want to thank the dedicated Aligning Systems for Health staff who supported this research. Glenn Landers and Kristi Fuller played an important role in strategically designing the research arm of Aligning Systems for Health and designing and executing the four rounds of requests for proposals. Glenn, along with Aliza Petiwala and Daniel Lanford, supported the researchers and provided thought partnership, particularly to the large research grantees. It goes without saying that I am grateful for the resolve of our research partners across the country who persevered in their research throughout the challenges of the COVID-19 pandemic. And I truly appreciate Aliza and Daniel's leadership in the sense-making process to identify novel findings, interesting themes and trends, and directions for future research out of the 21 research studies.

One of the core values at the Georgia Health Policy Center is continuous learning. We value the learning journey we have been on since the beginning of Aligning Systems for Health in 2019, and we are grateful for the opportunities this project has given us to learn from our research partners, the community of practice, communities, and each other. Aligning Systems for Health has taught us new things and re-emphasized insights we have gained from work across our portfolios and across our decades of experience. Our learnings often build off each other, lead to further refinement or clarification, and ultimately culminate in knowledge we can share with the field.

This book is one such product, as are the Toolkit for Measuring and Aligning (TEAM) and the Centering Community Voice principles and accompanying documentary. But Aligning Systems for Health benefits from all the preceding wisdom gained from researchers at the Georgia Health Policy Center. As the center continues its work with the next phase of Aligning for Equity, in partnership with the Institute of Women & Ethnic Studies, I believe that cross-learning will strengthen our work with communities.

The Georgia Health Policy Center has translated many of its learnings into usable tools that may aid funders, researchers, communities, and catalyst organizations as they strive to work together in new ways and fund cross-sector initiatives that hold the promise to transform communities so everyone has the opportunity to be healthy and thrive.

I urge you to take a look at this collection of tools that can complement the learnings found in this book and help communities develop innovative solutions to advance health, equity, and well-being.

The Assessment for Advancing Community Transforming: https://bit.ly/AACT-TOOL
The validated AACT tool was designed to help individuals and teams understand how far along their group is in its journey toward health transformation and what areas can be strengthened to help go further. Developed by County Health Rankings & Roadmaps, the Georgia Health Policy Center, and the Institute for Healthcare Improvement, the AACT tool brings people together to get a deeper understanding and agreement on where their group is in its work together.

Centering Community Voice: centeringcommunityvoice.org
Centering Community Voice is a movement to place the perspectives, opinions, and goals of community residents at the heart of community health system transformation with the goal of achieving equitable health outcomes for all. A free documentary, Centering Community Voice: Stories of Lived Experience, is available to be screened publicly as a way to introduce the importance of community voice and to inspire community residents and organizations to continue to press for changes in how communitywide efforts are identified, planned, and executed.

A Guide to Funding Navigation: fundingnavigatorguide.org
Understanding where there are high-leverage opportunities between community-identified needs, available funding, and impactful interventions requires an innovative mindset and funding navigation skills. Funding navigation is a skillset that enables finding the money in a system or across disparate systems and leveraging existing funds to create new opportunities across sectors. This collection contains at-your-pace trainings, practical tools, and a dynamic funding dashboard that are designed to support states, collaboratives, and local fiscal intermediaries in aligning resources and strategies across sectors to build resilient and equitable communities.

Advancing the Practice of Local Wellness Funds: localwellnessfunds.org
Communities around the nation are thinking innovatively about aligning streams of resources to sustainably support initiatives of shared interest and importance through the creation of local wellness funds. This toolkit is organized around the sources, uses, and structure framework and is filled with practical tools and information for those developing a local wellness fund, as well as anyone looking for a way to grow the impact of collective investments in community health and well-being.

The Toolkit for Measuring and Aligning (TEAM): measuringaligning.org
The TEAM is designed to help people and collaboratives measure their complex, cross-sector work, including if they are aligning, how well they are aligning, and how well they agree on their current status. The toolkit contains three assessments and a searchable database of measures that users can pull from targeting their area of focus.

- Karen Minyard
CEO, Georgia Health Policy

Introduction

Aliza Petiwala
Daniel Lanford
Kristi Fuller

The U.S. health care system incurs high costs, yet health inequities and worsening population health outcomes persist. Social determinants of health are cited as major contributors to health outcomes. Health care, public health, and social service organizations have worked within their own systems in addressing individual patient needs. Clinicians, practitioners, and researchers in these fields recognize the need to address social determinants of health and are more deliberately working together to tackle health inequities.

The Aligning Systems for Health: Health Care + Public Health + Social Services initiative was born out of this recognition for more deliberative and sustainable work between these systems. This initiative, supported by the Robert Wood Johnson Foundation and coordinated by the Georgia Health Policy Center, focuses on identifying effective ways to align health care, public health, and social service organizations to better meet the goals and needs of the people and communities they serve.[1] To aid in this effort, the Robert Wood Johnson Foundation and the Georgia Health Policy Center developed the original Cross-Sector Alignment Theory of Change, which highlights factors that influence collaboration between health care, public health, and social service systems.[2]

Starting in 2019, Aligning Systems for Health funded 21 grants to study how systems can better work together to address community goals and needs. The first book, Aligning Systems for Health: Two Years of Learning, details two years of learnings, including from the first six grantee-funded research projects.[3] Findings from the Georgia Health Policy Center and grantee-funded research strengthened the evidence base suggesting the importance of shared purpose, governance, financing, and data in cross-sector collaborative efforts. This work highlighted the interrelated nature of these factors. Trust, relationship-building, and leadership were highlighted as critical for how shared purpose, governance, financing, and data are developed. Findings also emphasized the importance of community voices in identifying, developing, and implementing projects to address community needs. The first two years of work also underscored the need for process and outcomes in these settings to be more equitable. Finally, researchers and practitioners highlighted that formal collaboration across systems can be a complex, time-intensive process that is highly dependent on local contexts.

Based on these learnings, the Framework for Aligning Sectors was updated.[2] The core components of shared purpose, governance, financing, and data remain relevant to collaboration

but were visually adapted to represent the interrelated nature of the components. Four additional factors were included in the new framework because findings highlighted the importance of these factors in the implementation and sustainability of collaborative systems: community voices, equity, power dynamics, and trust. Since building and sustaining collaborative systems may require changes in mindsets, policies, and practices, these were added as intermediate goals in the updated framework. As shown in the latest version of the framework, achieving these intermediate goals can help collaboratives work toward changes in the framework's long-term outcomes: meeting community goals and needs, health equity, and racial equity.

During the Aligning Systems for Health initiative, three significant inter-related events occurred that changed how people view health care, public health, and social service systems and their impact on health and racial equity: the COVID-19 pandemic, the resulting economic crisis, and the police killing of George Floyd, which sparked a new wave of nationwide racial and economic justice protests. These three co-occurring crises exacerbated long-standing fissures within and between health care, public health, and social service systems in the United States. Distrust for institutions was stark. Yet, there was also an urgency for collaboration created by the crises. Specifically, the need for collaborative systems that are subject to the needs of the communities they serve became more apparent. The initial findings from the Aligning Systems for Health initiative and the triple crisis moved many people toward deeper examinations of cross-sector systems, especially as they relate to addressing health and racial inequities. Subsequent initiatives that followed from the Aligning Systems for Health work were intended to illuminate more completely the elements that improve and sustain collaborative systems in different contexts, including within the context of COVID-19, and how these systems can be built and measured to better address community needs.

This book summarizes learnings from the last three years since the publication of *Volume 1*. During that time, two additional cohorts were funded with nine- to 12-month grants, and one continuing large cohort of grantees, funded at the start of the initiative for 24-month research grants, completed their work. These three cohorts produced the research found here in *Volume 2*. In this section, we provide a preview of what the rest of this book has to offer.

Chapter 1: Aligning to Respond to Crisis

Chapter 1 presents findings from four grantees that were funded to study how established collaborative systems responded to the COVID-19 pandemic. Albright and colleagues pivoted their housing initiative to focus on COVID services among their unhoused population and leveraged virtual platforms to keep communities engaged and were ultimately able to increase community participation. Brewster and colleagues found that a culture of adaptability, having management processes in place for monitoring and outreach, employing front-line staff with flexible skills to support health and social care, and having trusting relationships among organizations were key to the collaborative's resilience in the face of COVID. McCrae and colleagues found that having existing committees, contractual agreements, and collaborative data systems kept programs running when resources may have otherwise been diverted. Tuepker and colleagues found that focusing on relationships in community partnerships through relational organizing helped: engage communities in crisis response, start to build relational power in the community, develop trust with communities, recognize differential power dynamics in society and organizations, engage communities in conversations about their needs, and create vehicles for individuals to exercise their power. These grantees' findings delve deeply into how established collaborative systems in different contexts were able to quickly pivot to address the differing needs brought out by the pandemic.

Chapter 2: Measuring Aligning

Chapter 2 presents findings from four grantees that were funded to study how collaborative systems can be measured. Bultema and colleagues compiled, tested, and offered a theory- and practice-grounded set of measures for assessing progress in health-oriented collaborative settings. Hoornbeek and colleagues found that financial alignment in collaboratives is difficult and undefined, especially in terms of funding availability. For collaboratives looking to better understand their progress toward financial sustainability, the authors offer a multistage framework to consider. Salomon and colleagues focused on the role of equity in informing the measurement of interventions and how progress on equity is appraised. The authors suggest

a framework of six pillars to address equity in process and outcome measurements. Turi and colleagues studied how collaboratives identify, define, and measure value. They found that value is perceived differently by people in different roles, but there is agreement that collaboratives are valuable when they provide intrinsic benefits, engage communities, demonstrate outcomes, and lead to sustained systems change. Grantee findings demonstrate the importance of measuring equity, including measures beyond financial return on investment, and providing useful measures for elements of the Framework for Aligning Sectors.

Chapter 3: Adopting Aligning Approaches

Chapter 3 presents findings from the seven 24-month research grants that were funded to study the evidence base around approaches and conditions that foster collaborative systems, in particular the components of shared purpose, governance, financing, data, power dynamics, equity, trust, and community voices. Bultema and colleagues focused on a survey of perceptions about factors in the Framework for Aligning Sectors and their associations with each other. Most survey respondents indicated that collaboratives are helpful for aligning resources and activities, but the success of the collaborative was perceived differently among different groups. Creel and colleagues studied network connectivity across two sites, one rural and one urban, and found notable differences in collaboration between the urban and rural sites. Fichtenberg and colleagues studied the implementation of a multisector referral web application for community-based organizations and found uptake of the application in this context was difficult to increase, which may reflect the time needed for widespread adoption of a new tool and the disruptions to the adoption process caused by COVID. Oré and colleagues studied collaboration within the context of tribal health organizations. Findings highlighted the importance of cultural heritage integration with public health efforts, sovereignty in data, patience in communication, and integrated systems that reflect a focus on the whole person and community. Sanghavi and colleagues evaluated cross-sector aligning projects implemented across 20 sites in Texas. Their findings highlighted the importance of long-term investments in aligning efforts and maintaining trust with partners and community leaders built through prior positive relationships. Shapiro and colleagues assessed a health equity collaborative comprising six hospitals and other health

care, public health, and social service partners and found several tools that can be instrumental in building cross-sector alignment. Smithwick and colleagues incorporated community health workers in the design and implementation of their research project and identified several barriers and recommended solutions to engage communities in collaborations. They identify a need for funding structures to facilitate community engagement with long-term investments. Findings from this cohort of grantees support the evidence that thoughtful consideration of the framework components may help organizations work together toward developing and sustaining collaborative systems, but context plays a large role in how the elements are developed and implemented.

Finally, key lessons from all three chapters are highlighted in the conclusion chapter. The conclusion chapter also identifies themes and offers ideas for next steps that may be practical and applicable for practitioners and researchers alike. The conclusion seeks to assist the reader in considering how the findings from the research summarized in the volume may inform their work.

Throughout, readers will hear a repeated refrain for more thoughtful inclusion of community voices. Similarly, there are frequent calls for a re-energized focus on equity, especially racial equity, in both processes and outcomes. Heeding these calls, the next step in the Aligning Systems for Health initiative involves taking these learnings and applying them specifically to address structural racism. To that end, much of the ongoing Aligning Systems for Health work will build on work at four sites with established collaborative systems that are funded to explore how their collaborative systems, in conjunction with community leadership, can address issues related to structural racism in their communities.

Many of the findings from the previous work in this field speak to the importance of community voice in health collaboratives, addressing equity as a process and an outcome, and addressing power dynamics that inherently occur between funders, organizations, and communities. Yet there is still a long way to go in establishing community leadership in collaborative systems, impacting outcomes specific to community-defined needs, and dismantling structural racism. To better understand the roots of this work, and prepare for the next steps, review the following chapters, each of which is an important steppingstone in helping the field understand more clearly how to succeed with cross-sector health collaboratives.

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Chapter One

Aligning to Respond to Crisis

The COVID-19 pandemic disrupted the health care, public health, and social services systems in the United States in significant ways. Shifts were made in the delivery of essential services, organizations had to bolster collaborative practices to address needs, and long-standing inequities were magnified. In response to the crisis, the Aligning Systems for Health initiative released a call for proposals for research and evaluation projects to study how established collaborative systems were responding to the pandemic. Grants were funded for a total of $300,000 across four 9-12-month projects. The grantees studied collaborative systems across the nation in California, Colorado, Florida, Montana, Oregon, and Washington state. The awarded organizations, Chapin Hall, Center for Health Progress, Industrial Areas Foundation, and University of California at Berkeley, each studied varying aspects of collaboration within the context of COVID-19 and the impact on different populations. Findings ranged from how collaboratives adapted to respond to crisis to the leveraging of virtual platforms to keeping communities engaged in service delivery. Additional findings from each of the grantees can be found in this chapter.

The COVID-19 Pandemic's Impact on Organizational Capacity to Improve Health Equity in Colorado

Center for Health Progress

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Maria de Jesus Diaz-Perez*
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Theresa Trujillo
Joe Sammen

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The COVID-19 pandemic disrupted major systems in communities throughout the United States and the world. Among the results of this disruption was that the very people that our systems already disproportionately failed had even more difficulty in accessing critical resources. The pandemic also disrupted the internal capacities and workflows of numerous organizations. Here, we examine how the pandemic impacted the ability of two organizations — the Pueblo Triple Aim Corporation (PTAC) and the Center for Health Progress (CHP) — in their efforts to improve health equity in Pueblo County, Colo. Although each organization focuses on different populations, both seek to improve health equity among marginalized populations — that is, groups of people that have historically and intentionally been left out of traditional community engagement processes. Neither organization provides direct services, but both are highly collaborative and system-oriented in their efforts to facilitate improved health and social services for their target communities.

Consonant with the pervasive disruptions that it wrought, the COVID-19 pandemic impacted the ability of PTAC and CHP to engage marginalized community members, specifically the unhoused population, immigrants, and people in mixed-documentation families. Here, we document two specific impacts: how the pandemic affected PTAC's internal capacity to gather and incorporate community input in its cross-sector alignment efforts, and how it affected marginalized community members' ability to participate in CHP's community organizing efforts in Pueblo.

Overview: The Organizations

Pueblo County is located in the southern part of Colorado and has a population of approximately 170,000. The area has a rich history of Chicano civic and health activism and many multisector collaborations. PTAC provides the structure for a health-focused alliance across Pueblo County. In recent years, this alliance has focused on organizing and contributing to community advocacy efforts aimed at ensuring that systems exist to support the development of resources for safe and stable home environments — and affordable housing, in particular. Further, in early 2019, PTAC began organizing community advocacy efforts to address issues related to homelessness. PTAC and its collaborators have now facilitated county progress on many initiatives, including developing inclusive and equitable housing strategies, coordinating improved delivery of supportive housing services, creating services for homeless and runaway youth, and increasing the affordable housing inventory

in Pueblo County. In February 2020 — just before the pandemic's onset — PTAC formalized its work in this area by creating the Community Commission on Housing and Homelessness (CCHH). The CCHH brings together more than 43 community stakeholders from over 30 organizations; the goal is to create a strategic plan to guide the development of proactive efforts and community-level initiatives through 2025.

While PTAC focuses specifically on one county, CHP is a statewide organization that works in Pueblo County and beyond; its goal is to win recognition, rights, and resources for its target communities in the ongoing fight for health equity. CHP's work is founded on *community power building*, which it defines as: "The set of strategies used by communities most impacted by structural inequity to develop, sustain and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions and cultivate ongoing relationships of mutual accountability with decision-makers that change systems and advance health equity."

In Pueblo and other counties, CHP seeks to harness community power in order to hold health care and other systems accountable for meeting the needs of communities most impacted by inequities — especially immigrants, those with low incomes, and residents of color. CHP's organizing campaigns target local, state, and national policy change, including legislative, governmental, institutional, and local policies. Table 1 provides more information about each organization.

Table 1. Characteristics of Pueblo Triple Aim Corporation and Center for Health Progress

Organization Chracteristics	Pueblo Triple Aim Corporation	Center For Health Progress
Founding year	2012	1997
Location	Pueblo, Colorado	Across Colorado, including Denver, Fort Morgan, and Pueblo locations

Organization Chracteristics	Pueblo triple Aim Corporation	Center For Health Progress
History	PTAC was organized to bring together a working collaboration of health care leaders to improve overall population health, reducing per capita care costs and improving the care experience for all Pueblo County citizens. In 2019, PTAC began to shift its focus to address housing issues, and in February 2020, this work formalized into the creation of the CCHH.	CHP was originally founded as the Colorado Coalition for the Medically Underserved to ensure that everyone had access to high-quality, affordable health care. In 2017, it transitioned to the CHP with a renewed focus on power building and community organizing for action.
Mission	To make Pueblo the healthiest county in the state through community problem-solving and cross-sector collaboration	To build power to win recognition, rights, and resources for our communities in our ongoing fight for health equity.
Target population	Unhoused people	Immigrants, residents of color, and people with low incomes
Priorities and focus	PTAC's main focus is to provide a structure for a health-focused alliance across Pueblo County, organizing and contributing to advocacy efforts to ensure that there are systems to support the development of safe, stable, and affordable housing.	CHP's priorities are to grow a powerful base and invest in the development of core leaders, to effect policy in ways that build community power in order to change the design of health care systems and structures, and to create new public narratives about health and health care that transform what the community sees as real and possible.

Organization Chracteristics	Pueblo Triple Aim Corporation	Center For Health Progress
Framework	Collective Impact	Community Power Building
Partner organizations	With the CCHH, PTAC brings together more than 43 community stakeholders from over 30 organizations.	CHP leads or is a member of multiple coalitions and collaborative efforts, most of which focus on specific policy aims. It has also developed relationships with numerous local and statewide organizations.

Methods

We used a mixed-methods approach that actively involved community members and other stakeholders. To understand how the COVID-19 pandemic affected PTAC's internal capacity to gather and incorporate community input in its cross-sector alignment efforts, we first gathered and analyzed PTAC's internal records documenting plans and activities related to COVID-19 response, including its outreach to community members and to other community resources and agencies. Documents included minutes of all board meetings conducted from January to November 2020, documentation of work group assignments and updates, and a summary of populations served during the target period. Our analysis focused on mapping internal PTAC processes as the COVID-19 pandemic emerged, including the rationale behind outreach to potential community partners and community members. Our document review was supplemented by in-depth interviews with PTAC's primary staff members (n = 2) and board members (n = 4). These interviews focused on further assessing PTAC's internal processes and decision-making around its COVID-19 response.

To assess how the pandemic affected community members' ability to participate in CHP's organizing efforts in Pueblo County, we conducted in-depth interviews with their grassroots community leaders (n = 7) who led CHP's innovative phone-tree outreach effort from March through December 2020. These leaders had been deeply involved in CHP's community organizing

efforts since early 2020 and, when the pandemic hit, they worked to identify community members who were particularly marginalized — including immigrants, people who are undocumented, and people in mixed-status families — to determine their immediate needs and how to address them. Most interviewees were themselves immigrants, and all spoke both Spanish and English.

We used semistructured interview guides to facilitate interviews with PTAC's board and staff members and with CHP's grassroots leaders. In keeping with social distancing requirements, we conducted interviews via Zoom in the interviewees' preferred language. All PTAC board and staff member interviews were conducted in English; with the grassroots leader interviews, six were conducted in Spanish and one in English. We offered the grassroots leaders a $50 financial incentive for participating in the interview. The PTAC board and staff members did not receive an incentive. Each interview lasted approximately 45–60 minutes. We digitally recorded and transcribed all interviews verbatim. English and Spanish language recordings were transcribed in their original language, and the Spanish transcripts were then translated to English prior to analysis. We conducted our analysis in an iterative, team-based process using established qualitative content methods and reflexive team analysis.[1,2] Throughout the analytic process, our team members met regularly to discuss emergent codes and themes and to assess the preliminary results.[3,4] Our study was approved by the Migrant Clinicians Network Institutional Review Board.

Results: Pandemic-Related Changes

The pandemic's impact forced both organizations to make changes, and some of these changes resulted in unexpected benefits, as well as in process changes that will continue beyond the acute stages of the pandemic.

Pueblo Triple Aim Corporation

In April 2020, approximately one month after the pandemic began in earnest in Colorado, PTAC shifted its work — and leveraged its role as the CCHH facilitator to redirect that commission's work — to address the response and prevention of COVID-19 among the unhoused. This shift occurred after PTAC's executive director recognized an alarming gap in COVID-related care for

Pueblo's homeless population:

> **Pueblo has a large aging population, and our homeless population reflects that as well. So basically, the rescue mission became a glorified nursing home. And we had to figure out how we could get these people to shelter in place at the rescue mission, get access to all the things that they needed, and somehow prevent this illness from getting in there and spreading like wildfire. Because you cannot socially distance in a shelter, it is just not practical. While they enforced mask washing, or mask wearing and hand washing, and you know, disinfecting, it's just not a place where you can all have six feet between you. It's just not realistic. So, we needed to find a way to bring hygiene options to people. Another part that compounded the issue is that all the parks closed down their bathrooms, which is not something people think about, but that's where a lot of homeless people were accessing water and hygiene again. And so now they lost access to not only hygiene, but drinking water, for that matter. So, you know, it was very, very much compounded by the virus, with everything closing down. People just did not have access to the things that they needed.**

Given the scope of the problem, the executive director rallied the CCHH to act; one board member describes this effort as follows:

> **It was definitely a joint effort, but [the executive director] used all of the people that she knows and the pull that she had at the county commissioners and city council. Because the homeless piece was just, you know, it was right in our face. So, she was working to make sure that that was part of the conversation, making sure that people were getting places to stay. She was facilitating bringing people together on it. It wasn't a direct-care kind of thing, but she was working, right? She was bringing people together on the problem..**

The CCHH, under PTAC's facilitative leadership, quickly began to design and enact collaborative efforts such as symptom checking at the local soup kitchen and rescue mission and hand-washing station installations in areas frequented by unhoused people throughout Pueblo:

It was very, very collaborative. You know, there's a lot of communities in this country that are much more sophisticated around homeless response than Pueblo is. And we looked to that, to be quite honest with you. We started out with like, 'Hey, what can we do?' and people started researching what other communities were doing, not even necessarily during the pandemic, but just in general. And one of the first things we found were portable hand-washing stations — that these were a big thing, a huge thing for the population to be able to just wash their hands. So, we started out pretty basic with that. PTAC was able to get a grant from Pueblo County's law enforcement assisted diversion program, or LEAD program, to rent hand-washing stations and place them at four locations throughout town for about approximately two months, but that was all the funding that there was for that. But then we worked with our people who focus on unaccompanied youth and runaway youth. And they had some funding —and they're like, 'Hey, you know, we can actually buy the supplies to make our own permanent hand-washing stations instead of paying $1,500 a month to rent these four.' And so, we're like, 'OK, well, … we can buy the products, but who's going to put them together?' And then we found a way to partner with the Upward Bound students who needed a project anyway. And so on. So, in the end we bought all the supplies and we created six permanent hand-washing stations that we've now placed throughout our town.

Given social distancing concerns, PTAC's regular bimonthly meetings with stakeholders and community members shifted from in-person to a virtual format, which initially diminished participation and engagement. However, over time, stakeholders grew more comfortable with the virtual format, and participation increased. One board member characterized the shift to a virtual format as follows:

Honestly, it was a hard pivot. We had been used to meeting in person, and it took some getting used to. Participation kind of fell off at first, but then again it was a weird time and everyone was scrambling. But then, you know, we just got used to Zoom life. And that's just how it is now.

PTAC further adapted by adopting a Likert scale to evaluate participants' experience of the meetings and to help it understand how to make meetings more meaningful. Dissemination efforts also increased; PTAC began sending emails to members to share information about what the different PTAC coalition organizations are doing and how people can get involved in those efforts.

Center for Health Progress

In response to the pandemic's onset, CHP shifted its in-person community organizing work to fully virtual work that focused more on connecting people to direct services rather than on engaging in policy and advocacy. The centerpiece of this focus was CHP's efforts, from March through December 2020, to develop and use an innovative phone-tree method to continue the work of the field teams — including CHP community organizers (COs) and CHP-affiliated grassroots leaders — despite the pandemic's limits related to social distancing requirements. This novel outreach approach allowed CHP to actively communicate with immigrants and ascertain their needs regarding COVID-19, health care access, and the policies needed to facilitate an inclusive, equitable pandemic recovery in Colorado. The COs trained the grassroots leaders to conduct the phone-tree outreach, and the grassroots leaders identified outreach recipients through formal snowball sampling and direct need-based referrals. CHP used the information generated by the phone-tree outreach —

- To connect community members with general resources (e.g., food banks, rent assistance);
- To facilitate access to health care (e.g., providing support to enroll and understand Medicaid, or to access testing and vaccination);
- To enroll eligible families in Pandemic Electronic Benefits Transfer; and
- To launch a relief fund for individuals with significant needs.

COVID-19 had a significant impact in Pueblo's immigrant community, whether because they lost their jobs due to closings, had their hours reduced, or fell ill and were unable to work

for weeks at a time. It also had a significant impact on the community's mental health, as one grassroots leader describes:

> **They've lost their job, their hours have been cut short. … Some people have symptoms and they do not want to go to the doctor because they are afraid, because they need to give their personal information and they fear they will be … well, yes, that they will be deported after they give their information. I've come across some people who do not want to be tested: 'I'll be quarantined, and I don't want that; I have bills to pay.' That has also happened. … I've seen so many people stressed out. They are down with depression and stress, and I'm not talking about adults only, but also kids.**

Despite the obstacles, grassroots leaders reported that community participation in CHP's organizing efforts increased during the pandemic. Before the pandemic began, the immigrant community had some knowledge of CHP's work and participated to a modest degree. However, the pandemic's onset and CHP's response to the crisis resulted in significantly more activity. Grassroots leaders reported being able to participate more during the pandemic because they had more time: their work hours were reduced, they did not have to drive to work, and their children did not have extracurricular activities. They also mentioned the advantage of being able to reach out to more people over the phone, as well as to meet with the CHP COs and other grassroots leaders via Zoom. The latter was especially convenient, they said, because the COs thoughtfully consulted with them about their schedules before setting training and meetings times:

> **And now, because of COVID, I am able to reach out to more people, and it's easier because almost everything is through Zoom or the phone. And now I have more time to do it because I am at home.**

> **I think what they [CHP COs] are doing is working just fine: the way they include me, how information is sent to me, and the time I devote to log in. I mean, I think it is working fine, I am comfortable with the way things are, I don't feel under pressure, I feel fine. The schedule is always good. They ask us over the phone. … They take decisions after we all give our answers. 'What time can you do it?' And we tell them the time, right?**

When CHP established the innovative phone tree, it did not engage with other local partners to make that decision or to implement it. However, CHP leveraged its Coalition for Immigrant Health to help disseminate accurate information and resources for immigrants through word-of-mouth outreach, flyers, and a central resource hub on a website as well as to coordinate on policy responses to the pandemic. CHP also developed or collected from others resources to help families access health care and fulfill other basic needs.

Once the phone tree started and other Pueblo-based organizations learned about CHP's new outreach efforts, local social service agencies (e.g., food and rental assistance) contacted CHP's field team to request help spreading the word about resources they had available in response to the COVID-19 emergency. Grassroots leaders talked with the immigrant community about the process for receiving services and helped increase the community's confidence in how their personal information would be used. Grassroots leaders also provided language assistance and instrumental help in areas such as transportation and food delivery when community members were sick or lacked access to transportation.

Grassroots leaders indicated particular satisfaction with their ability to connect people with needed resources through the phone-tree outreach, especially among people who do not speak English:

> **I feel like those of us who are bilingual can do a bit more for those people that don't understand English. I think that I am more involved now, with a little bit of fear, because of the pandemic, because I also had COVID, but I like the idea of helping out. I mean, I think that I am going to be useful to those people who don't know how to speak English.**

Grassroots leaders stressed that to motivate the immigrant community's participation, it is important to have Hispanic and Spanish-speaking people in positions of authority in the community. They also cited as important their experiences gained through participating in the phone-tree rounds and the training received through CHP. This training included leadership, public speaking, and advocacy, in addition to phone-tree-specific training (e.g., the process of collecting and recording data and resources to share with community members):

I have more self-confidence. Because the truth is that I used to be a bit fearful about speaking to people, and I was fearful about doing a lot of things. But, thanks to this, I have learned a lot and they have taught me how to talk to people.

So, it is not just about … us being volunteers; [CHP is] helping us to develop as individuals. They could simply keep the ladies who are already leaders, but they are on the lookout for more leaders, for more people to help and to support the community. They encourage us not to be afraid to talk, to ask questions. That is the idea that is most deeply rooted. They call on the community to keep on helping with this endeavor to find things to help us as immigrants, and that just because we are undocumented, we should not have doors slammed shut on us.

Each grassroots leader established bidirectional communication with their phone-tree members, increasing their individual outreach from 10 to up to 50 people. The number of grassroots leaders participating in this outreach also increased from 10 to 18, expanding CHP's community base. The reports of the phone-tree outreach were shared by CHP COs with grassroots leaders and with the CHP's policy team. Data collected by grassroots leaders supported CHP communication with state legislators and state health agency representatives about the urgent needs of immigrant groups during the COVID-19 emergency.

Discussion

The COVID-19 pandemic introduced logistical challenges for organizations throughout the country, and many cross-sector alignment efforts have struggled to navigate capacity challenges and social distancing. Insights into how PTAC and CHP approached these challenges to enact meaningful and beneficial change are thus instructive. The data resulting from our study underscores the significant health care needs of marginalized populations and highlights the urgency of response, particularly in the face of a population-level emergency such as the COVID-19 pandemic. In such public health emergencies, health inequities for marginalized populations are further exacerbated. The approaches that PTAC and CHP utilized to engage and access community members demonstrates

their effectiveness in (1) enabling direct connection to communities affected by potential policy changes, while simultaneously (2) building collective policy analysis and the capacity of community members and (3) laying pathways to translation and implementation of research into policy.

As soon as the COVID-19 pandemic started, these two organizations were able to redirect their work to address urgent needs for their target populations (i.e., the unhoused, immigrants, and mixed-documentation families). This quick redirection of resources was possible because each organization activated its existing networks. PTAC, as a leader of the CCHH, was able to activate services provided by several CCHH alliance member organizations. Such a rapid response was possible only because of the relationships built through PTAC's long-standing convening role in Pueblo. In the case of CHP, its Pueblo COs are longtime residents of the county and had worked to develop deep relationships with community members, including the grassroots leaders, long before the pandemic. Because of the existing, trusting relationships between the grassroots leaders, who are members of the Pueblo immigrant community, and the CHP COs, CHP was able to implement an immediate response, including to link immigrants with appropriate resources and to bridge one of the most problematic barriers to immigrants accessing services: their distrust of organizations. Using a phone tree, grassroots leaders systematically identified immigrants' needs and connected the immigrants with food systems and health care, and eventually with vaccine clinics. The fragmented nature of Pueblo's various health and social services (e.g., food banks, cash assistance, COVID testing) was informally addressed to some extent by CHP curating resources, making them available to immigrant families identified through the phone-tree outreach, and building immigrants' confidence in their ability to access services without negative consequences for themselves or their families. Once the phone-tree implementation began, several local organizations reached out to CHP as new partners seeking to have their services disseminated to the community via the phone tree.

Conclusion

Aligning Systems for Health's Cross-Sector Alignment Theory of Change is instructive in helping to illuminate why PTAC and CHP were successful during this unprecedented time of need in Pueblo. Our interview data clearly shows that the COVID-19 pandemic acted as an external

factor that created a significant sense of urgency in the community that PTAC and CHP were able to leverage to create an impetus for deeper alignment across partners and sectors. In addition, COVID-19 acted as a unifying force that both aligned PTAC's membership, which represented various sectors and helped steer CHP's partners toward a clear, shared purpose. In the case of PTAC, members aligned to address the significant pandemic-related needs of Pueblo's unhoused population. For CHP, community partners aligned closely with CHP's field team around the shared purpose of meeting the immediate pandemic-related needs of Pueblo's mixed-documented and undocumented families. These shared purposes created an "all hands on deck" mentality across the diverse stakeholders engaged by PTAC and CHP and provided a clear impetus for involvement and a clear priority for interventions. Concurrently, grassroots leaders' participation in the phone-tree outreach and their continuous leadership training provided by CHP increased these leaders' confidence in their ability to address community members' short-term needs as well as their ability to grow CHP's community base in Pueblo. The grassroots leaders reported that they are now more secure in their ability to advocate for themselves and their communities. Later in the pandemic, when vaccine efforts were in place, these leaders played an important role in ensuring that immigrant community members had access to the vaccine. As the Cross-Sector Alignment Theory of Change suggests, the strong community role and engagement was a significant facilitator of CHP's success. Centering grassroots leaders to distribute and share power is a key component of CHP's approach to health equity work; this approach had a beneficial effect on community members' ability to participate in CHP's community organizing efforts in Pueblo. Successful power-building organizations have the unique ability to build deep relationships with a constituency of historically marginalized or underrepresented community members. To be most successful in advancing structural changes, these relationships must be — "Independent (meaning the constituency can spring into action without a donor … giving the organization resources to activate it), committed (meaning the constituency is loyal to the organization and to each other), and flexible (meaning the constituency will shift with the organization even as the political choices and terrain shift)."[5]

As our study shows, the embeddedness of this outreach in a community power-building organizing model enabled immediate action and an expanded base of independent, committed, and flexible power that helped realize structural change in Pueblo.

Our study is limited in generalizability because of its focus on two community-based organizations in a single state. However, this focus was necessary to provide both breadth and depth within our specified universe. We expect that this work will contribute to generalizable knowledge of cross-sector alignment that will inform how other organizations might withstand significant systemic shocks, such as the pandemic, as well as provide evidence of the effectiveness of a community power-building approach among marginalized populations.

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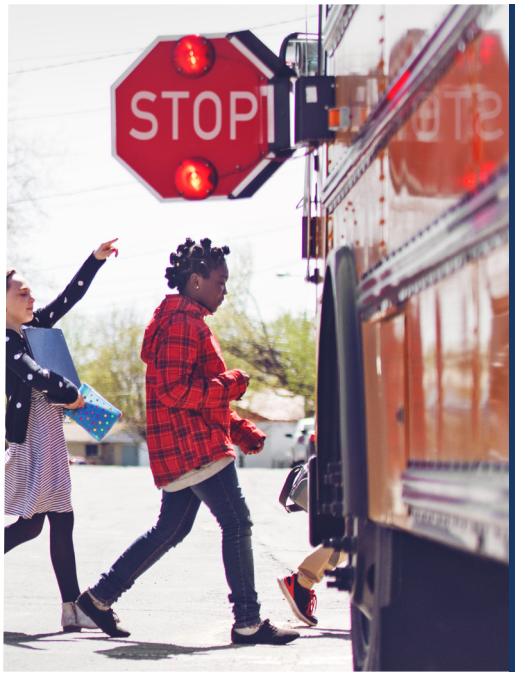
Elevating Community Assets to Address Family Needs During the COVID-19 Pandemic



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The ongoing challenge of COVID-19 brings enormous demand for communities and systems to address and mitigate health and other related impacts on families. The urgency of the pandemic stressed systems that were already struggling to grow, align, and integrate cross-sector capacity. Organizations were forced to pivot to accommodate new health challenges and manage concomitant psychological and economic stress in the population, all while altering their existing ways of practicing. Emerging literature on cross-sector alignment shows that leveraging family strengths as part of organizational change efforts can mitigate risk of chronic stress and reduce disparities in health.[1,2,3] Established ingredients of these cross-sector change strategies include a clear vision, adequate resources, and progress-monitoring systems.[4,5] Critical drivers of effective cross-sector alignment include how leadership and decision-making are distributed, yet we know relatively little about how this alignment impacts health and health equity due to the limited scale and implementation duration of promising models.[6,7]

As the COVID-19 crisis persists, it is important to understand whether policy responses to the pandemic are deepening the commitment to cross-sector alignment or signifying a retreat to more centralized, single-system responses. Understanding the policies, practices, and organizational relationships that contribute to these trajectories — and how families experience the resulting adaptations — is critical to sustaining and scaling cross-sector alignment beyond this crisis and informing our responses to future ones. The ability of families to access health care, public health, and social services is particularly important in relation to families with young children because COVID-19 dramatically reduced access to critical early care and education experiences at a key time for brain development and resilience building. Moreover, pre-existing structural inequities mean that low-income, under-resourced communities experiencing underemployment and low-wage jobs have higher rates of illness; they have also been hit hardest by the pandemic.[8] Consequently, children in families with high adversity before the pandemic face new risks to health and well-being due to limited access to care, economic hardship, and service gaps.

Our study extends a previous longitudinal study, *Evaluating Community Approaches to Preventing or Mitigating Toxic Stress*, a three-year, five-community study of pediatric health care innovations to screen, refer, and link families to resources and thereby address social determinants of health and prevent toxic stress in infants.[9] That study focused on five communities; here, we focus on three of those communities: Palm Beach County in Florida and Alameda and Los Angeles

counties in California. We chose these communities because they represent two states with distinctly different pandemic responses and, prior to the pandemic, both had a strong foundation of cross-sector alignment that included early childhood health care partnerships to address families' concrete and social needs. Our goal was to understand community responses to the pandemic and families' experiences with accessing resources before and after the onset of COVID-19.

Study Overview

Our study focuses on two research questions:

- To what extent do the level and nature of social service and concrete resource needs experienced by families during the pandemic differ?
- In what ways did communities with prepandemic collaboration in health care and early childhood mobilize to meet family priorities and needs during the pandemic?

Interview Types and Participants

Our study is based on two types of interviews: survey interviews with 244 families with toddlers who had also been interviewed prior to the pandemic and qualitative interviews with five stakeholders in each community.* We conducted the latter interviews (with system leaders) virtually during a five-month period (November 2020–March 2021); these sessions were audiotaped and transcribed.

The family interviews were held virtually or by phone during this same period and were conducted by bilingual, bicultural community-based field interviewers.† We randomly selected families from the sample that had previously completed a final interview for the earlier study when their babies were 12–15 months old. Family characteristics differed across communities. Families

*We interviewed two early childhood leaders, two public health leaders, and one health care leader per community.
†Pre-COVID family interviews were conducted at three time points between March 1, 2019, and February 29, 2020 Our current study's family interviews were conducted over a 10-week period (December 2020–February 2021).

in Palm Beach had higher incomes and were more racially and ethnically diverse, while families in Los Angeles and Alameda County were primarily Hispanic. Nearly all respondents were mothers.

Goals and Measures

Our focus on resource access and security for the family interviews is reflected in our questions. We asked families whether, since the pandemic began, they had needed any of the following social supports for at least one month (yes or no): cash assistance (TANF); food assistance (SNAP); Women, Infants, and Children (WIC) program; rent or housing assistance; or public health insurance (Medicaid). Families with reported need were asked whether they had received it for the indicated type of assistance. We created variables to indicate unmet need for TANF, SNAP, WIC, housing, and Medicaid (1 = need but no receipt; 0 = no need or satisfied need). We asked two questions to further assess food insecurity: "Did you worry that your food would run out before you got money or food stamps to buy more?" and "Did the food you bought just not last, and you didn't have money to get more?" Participants responded with a yes (1) or no (0); we created a dichotomous variable to indicate if a family answered yes to either question. Families had been asked these same questions in their prepandemic interviews.

Our interviews with system leaders investigated community mobilization in response to COVID-19. Interview topics included the initial and evolving needs of families, sector-specific and cross-sector responses to COVID-19, the role of equity and community/family voice in decision-making, and reflections on the effectiveness of community responses.

Data Anlysis and Results

We adopted a specific approach to data analysis for each type of interview. In the following sections, we describe those approaches and the resulting findings for the family surveys and the community leader interviews separately.

Family Surveys and Findings on Resource Needs

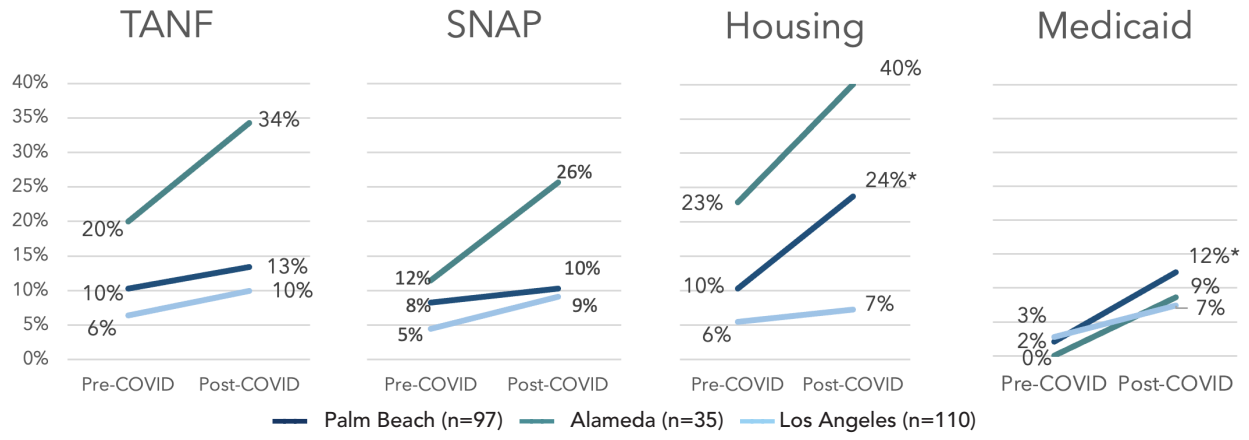
We conducted bivariate mean comparisons to examine how unmet needs and food insecurity

among families changed in the year following the initial pandemic restrictions. We calculated the percentage increase as the absolute difference divided by the pre-COVID value.

Figure 1 shows the change in unmet service need for TANF, SNAP, housing, and Medicaid. Families in all communities reported increases in unmet social service needs. Families in Alameda showed higher rates of unmet needs for TANF, SNAP, and housing assistance than the other communities at both time points. Compared to the onset of COVID-19, in Alameda, unmet need for TANF increased by 70%, unmet need for housing increased by 74%, and the unmet need for SNAP more than doubled. The lack of statistical significance in Alameda is likely a result of insufficient power to detect differences due to the sample size (n = 35). As such, it seems that Alameda — a community with significant need prior to the pandemic — saw those needs further increase over the course of the pandemic.

Interestingly, Palm Beach — which, of the three target communities, reported the greatest economic resources among families — also reported significant increases in need since the onset of COVID-19, particularly a 50% increase in unmet need for Medicaid and a 140% increase in unmet need for housing assistance. In Los Angeles, the change in unmet need since the COVID-19 onset was largest for Medicaid (130%), followed by TANF and SNAP (67% and 80%, respectively). Los Angeles reported very little change in unmet need for housing.

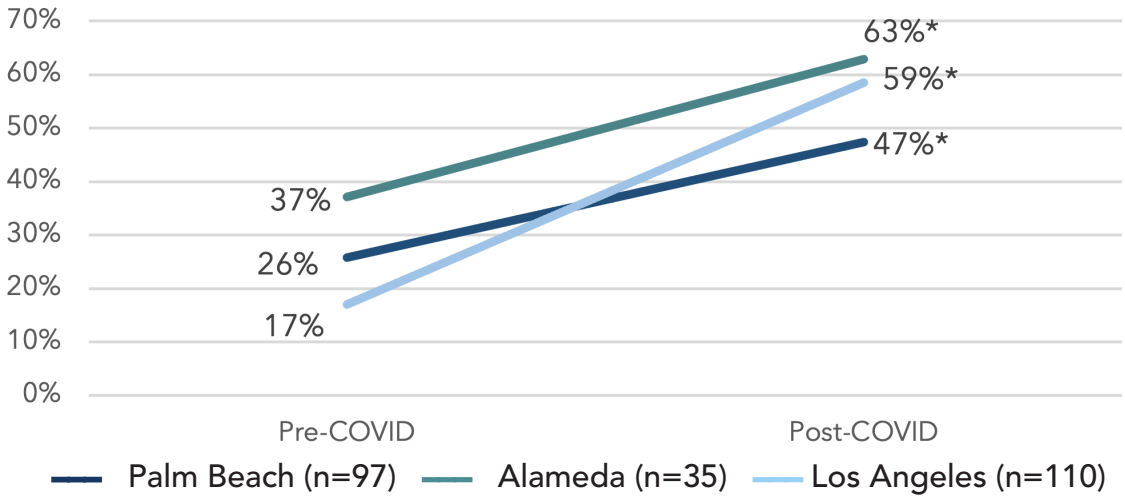
Figure 1. Changes in Unmet Service Need Pre- and Post-COVID[§] Onset



[§]Significant changes from pre- to post-COVID onset are denoted with a * ($p < .05$). Because the unmet need for WIC was very low and had limited variation across communities, it is not included in the figure.

As Figure 2 shows, families in these communities also saw significant increases in food insecurity; the largest increase was in Los Angeles County, where families experienced a nearly 250% increase.

Figure 2. Changes in Food Insecurity Pre- and Post-COVID Onset



Taken together, these findings highlight the significant strain and additional needs of families across *all* communities over the course of the pandemic; only the nature of the unmet needs varied by community. Unmet need overall may reflect families newly eligible for these programs due to the pandemic and the lack of an adequate existing system structure to assist families needing specific resources for the first time. Also, if families are newly eligible, the unmet need could reflect a lack of familiarity with eligibility criteria and challenges with navigating program administrative requirements. Further, community systems may have lacked the staff or other capacity to meet the increased demand; such resource strains likely varied by type of service. These factors emphasize the value of using place-based analysis of service challenges in real time and an opportunity to process-map each system's barriers — such as lack of awareness or resource and staffing challenges — that may contribute to unmet need in different areas.

Community Leader Interviews and Cross-Sector Alignment Components

We developed a coding scheme based on the Cross-Sector Alignment Theory of Change[10] and on a review of public announcements and other documents describing each community's COVID-19 responses. We then systematically coded and used within-case and across-case data displays to explore the role of purpose, governance, financing, and data in how the communities mobilized.[11]

Evidence early in the pandemic showed widening racial and ethnic gaps in COVID-19 incidence; system leaders said this helped accelerate existing commitments to equity in decision-making about responses to COVID-19. One public health leader characterized this as follows:

> **Living through COVID-19 and this new kind of social justice revolution reinforces a vision that we developed already. It's not new, but it renews the commitment … and it forces you to refine your dedication and your commitment during this time.**

Consistent with the increased unmet needs that families reported, leaders across communities described a fuller understanding of critical opportunities to center the end user — the family — in their cross-sector alignment and systems-change initiatives. As one early childhood leader reflected, "when the pandemic hit and went beyond the week or two that everybody thought it was going to be … our systems were not ready nor were they aligned."

Such cross-sector partnerships were particularly valuable where the crisis widened existing service gaps. One public health partner noted that an early childhood organization's support had been critical to breaking down barriers and addressing needs experienced by families that her own agency was unable to finance or lead. "There is the disconnect with, 'Oh no, we can't do that because we're [a public health agency],'" she said. Having an established partnership with the early childhood organization facilitated the ease with which various organizations could fill emerging resource gaps as they were recognized.

Another organization leader observed that the pandemic and economic disruptions facilitated a pivot in her system's internal decision-making away from centering on "what we do" toward "who we serve." Such a shift drives the increased use of differentiated, community-

specific strategies, and it was explicitly part of COVID-19 relief in all three communities — both for early childhood funding specifically and for public-private COVID-19 relief efforts in general. Organization leaders created requests for applications and asked existing contractors and nonprofits to propose scopes rather than respond to system-defined priorities, a substantial shift from prior practices. The resulting scopes included concrete supports such as rental assistance, gift cards for groceries, and bus passes. Early childhood and public health leaders described relying on relationships they had developed with parent leaders and community-based organizations to guide the supplies they purchased and how they distributed them, rather than strictly adhering to alignment with strategic plans or system-defined benchmarks; this was also a shift and a breakdown of silos, as an early childhood leader described:

> **With COVID, it became much more OK to step in and — even if it's not your typical role — to connect and make referrals for concrete services and give [families] a list of places where [they] can access food.**

Theory of Change: Contributing to a Flexible Response

Our study found that system leaders viewed their communities' cross-sector foundations as important to their ability to transcend their "boxes" and create flexibility in long-standing practices. Further, as we now describe, the Cross-Sector Alignment Theory of Change's core components of purpose, governance, financing, and data overlapped in ways that proved mutually reinforcing.

Purpose

Cross-sector partnerships with previous shared purpose and priority outcomes were able to revisit this purpose and apply it to the current situation, reinforcing values that partners had previously agreed on but that had either waned or not yet been precisely developed. System leaders reported that their executive leaders had assigned equity as a priority, which was critical; they further noted that this vision of and commitment to equity was common among staff members at organizations as well. For example, in two communities, leaders pointed to public health staff with

early childhood expertise as key to translating high-level public health policies into actionable guidance and opportunities for childcare providers and programs serving families with young children. Leaders also cited existing cross-sector committees and sector-specific parent leadership councils as critical structures that helped to steer COVID-19 emergency responses.

Governance

Cross-sector governance that included previously existing "hard" mechanisms — such as memoranda of understanding, contracts, jointly funded positions, and board or commission membership across sectors — greatly enhanced communities' ability to rapidly implement solutions once the pandemic emerged. Leaders described these mechanisms as providing a framework for cross-sector alignment in the time of COVID-19. Such structures were particularly helpful when it came to addressing the unintended consequences of early COVID-19 responses.

For example, in each community, health care policymaking that restricted access to birthing hospitals and pediatric primary care settings meant that screening for basic needs that was provided by community-based organizations in those health care settings typically ground to a halt during the pandemic. Leaders reflected that the memoranda of understanding and other cross-sector structures were key to being able to elevate issues to pursue practice changes — in this case, asking nurses to administer social needs screenings or getting a hospital's permission for early childhood staff to screen families with newborns by telephone. As one early childhood leader explained, "we have a contractual agreement. … It was really a matter of us making some adjustments in how we do that work."

Still, our interviews showed that differences in governance structures affected staffing and services available to families with young children. Early childhood and public health systems saw significant drops in home visiting program referrals, which frequently had come through their health care partners. In one community, for example, public health nurses were redeployed to staff COVID-19 responses, rendering the home visiting programs unable to accept new referrals for two months. The result? As one public health leader noted, "it was like turning the water faucet off and on. 'Yes, send us referrals.' 'No, don't send them to us now.'" In another community, existing contractual arrangements facilitated continuing these programs; because the early childhood

system contracted with public health to operate home visiting services, home visitors were not redeployed like other public health staff.

Financing

In terms of systems adapting and implementing practical changes, a key critical strength we found was an ability to implement virtual services and finance the transition to them. Federal CARES Act funding — and the urgency to efficiently disburse these dollars — brought together long-standing and new partners to coordinate the implementation of virtual services and related strategies to connect families to additional resources. In describing the coordinated approach that her community adopted for the CARES Act, one leader noted:

> **The way that the county and city have been able to work together and also learn from each other and not have to duplicate work — I don't think I've ever seen that before.**

Medicaid and home visiting funding flexibilities also drove a rapid shift to virtual service provision for the first time for home and pediatric well-child visits. And, as one public health leader observed, "there have been places where that has not only worked, but maybe even opened some doors."

We found less adaptability to shift program dollars among agencies that relied on the volume of families served, such as for home visits or well-child visits. As one public health leader noted, different funders have different flexibility, "but very few are willing to simply shift their money, whether federal or private, to COVID-19 response." So, while system leaders reported that funders gave them flexibility in terms of delaying programs and enrollment goal deadlines, many organizations still faced intractable financial issues.

Data

Having data infrastructure and a history of partnership related to data greatly enhanced communities' ability to target resources, albeit with limitations on capacity. System leaders

described newly created public health data dashboards and other data reporting during COVID-19 as critical tools that they used to align and focus their response efforts. This information helped guide governance and financing decisions that underpinned cross-sector mobilization efforts. At the same time, leaders noted that the need to respond to COVID-19 for population health left little bandwidth for data system and measurement investments that could focus on specific subgroup needs — in this case, families with young children. There were two notable exceptions, however. First, essential workers had to be matched with emergency child care providers during COVID-19. To address this, early childhood systems coordinated with regional agencies to integrate data about child care availability and closures countywide for the first time. Second, early childhood and health care systems began running reports more frequently, disaggregating their data in different ways, and finding new ways to gather feedback for decision-making. Leaders also reported gathering community and family input via focus groups and surveys but noted that the data collection efforts did not go far enough toward centering community and family voices. With systems designed largely absent community involvement, one early childhood leader noted that the pandemic opened a critical opportunity to "let go of how we measure success and really understand how the community measures success."

Conclusion

The COVID-19 pandemic has been an ongoing public health crisis that significantly strained families and the systems serving them. We identified several overlapping system strengths in core components — purpose, governance, financing, and data — that existed prior to the pandemic and contributed to communities' agility in the crisis. Where these core components prove mutually reinforcing, they can powerfully contribute to enhancing the timeliness and relevance of information needed to guide decision-making in a crisis. Consistent with a comprehensive review of cross-sector alignment, this study illustrates the dynamic nature of shared purpose,[12] with formal and informal partnerships at the individual, organizational, and system levels contributing to community responses. At the same time, the widening gaps in family access to critical supports elevate the need to better focus on the end user and equity. Families reported that emergency assistance for survival-related needs — such as money, food, housing, and health insurance —

were lacking, despite significant federal investment in the economy and substantial flexibility in distributing resources. Our study shows that infusing local investments in cross-sector alignment is a critical aspect of the solution, offering frameworks and the infrastructure needed to flexibly funnel supports to families with young children in future public health emergencies.

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Expanding the Table: Three Relational Organizing Responses to the COVID-19 Pandemic

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Equity and inclusion have long been priorities for many people and communities working to improve health in the United States. Generations of health professionals, activists, and researchers, often from communities of color, have centered these values in their visions of what health care ought to deliver. The COVID-19 pandemic and the 2020 social justice uprisings called attention to the need for those in power — be they policy-makers or politicians — to acknowledge what some have argued for generations: that change should be led by communities most impacted by health inequities, who have traditionally been denied formal power and authority within health care and other inequity-producing systems.

Relational Organizing and Aligning Systems

Community organizing to address health issues has a long history and ongoing presence in the United States.[1,2,3,4,5,6] Organizing within health care organizations or delivery spaces, however, is fairly new. In 2016, Industrial Areas Foundation Northwest (IAF-NW) began working with affiliated organizations in the region to see if relational community organizing could be embedded within health care to advance health equity. Relational organizing builds long-term relationships, which it views as key to cooperative action to address meaningful issues in the lives of community members.[7,8,9] Rather than advocate for community members, developing leaders among them and working alongside them is central to this "emphatically bottom-up"[10] approach. That is, sharing life experiences, listening deeply, and discerning individuals' and communities' interests are not a "preamble" to getting down to work — they *are* the work.[11] Through understanding the passions and pressures in one another's lives, relational organizing overcomes internalized social divisions and engages leaders in developing a shared vision of the common good. Community members become leaders in their own right, understanding and recognizing the individual as well as collective power that they can hold. This shifts existing power dynamics away from traditional experts or formal power-holders to recognize ordinary people as leaders and experts in their own communities' needs. This developed sense of agency and ongoing collective solution-seeking among community participants is the "relational power" that relational organizing seeks to build. As recent researc[12] has highlighted, in the field of health policy, there are different definitions of *community voice* and how to bring it into program and policy development; relational organizing is among the approaches that centers community agency is a central concern.

Relational organizing emerged from a different lineage than the health research, policy, and advocacy sectors in which the Framework for Aligning Sectors originated. However, both share a stated assumption that improving health requires actions that reflect community priorities.[12] This chapter shares our findings from a rapid qualitative research project funded by the Georgia Health Policy Center's Aligning Systems for Health program with support from the Robert Wood Johnson Foundation.

Here, we examine how a trio of relational organizing projects — one each in Missoula, Mont.; Portland, Ore.; and Spokane, Wash. — responded to the COVID-19 pandemic. We describe the experiences and impacts of each project, then discuss how our findings contribute to the understanding of how relational organizing supports efforts to align sectors. We begin by introducing our three sites and summarizing the activities they undertook in 2020.

Context: Three Study Sites

We chose our three study sites based on the pre-existence of a collaborative network for sharing practices and lessons between these three sites. The IAF-NW health equity organizing initiative supported the development of the Health Equity Circle, a network of student organizations, and had been developing a cohort of clinic organizing efforts in Portland, Spokane, and Missoula that laid the basis for collaboration. Each site has complete autonomy to design a program that built on its own strengths and responded to the perceived needs in its communities. The three sites and programs are described briefly

Spokane

At the end of March 2020, the Spokane Alliance launched its Covid Community Monitoring Program to help people who contracted COVID-19 and — due to the pandemic's strain on the health care system — would likely have to care for themselves alone at home. To set up the program, the alliance worked with the Washington State University Elson S. Floyd College of Medicine (ESFCOM) and the Spokane Regional Health District (SRHD); it also recruited and trained 300 volunteers and a pool of volunteer clinicians to monitor people with COVID-19 who were quarantined at home.

SRHD offered people diagnosed with COVID-19 the opportunity to enroll in the program, then forwarded their contact information to the Spokane Alliance. The alliance then gave each program participant a pulse oximeter, procured by ESFCOM, for a 10-day monitoring period. Each day, volunteers called participants to monitor their medical condition for worsening that would require transfer to the hospital. Volunteers also asked participants about other social pressures such as food, housing and utilities, and isolation.

Portland

The Social Connection Project (SCP) was launched in Portland, Ore., in April 2020, when health care professionals and trainees recognized that the COVID-19 physical distancing mandate might increase social isolation and loneliness. SCP paired trained volunteers with more than 100 participants who self-identified as experiencing social isolation or loneliness. Through this one-on-one longitudinal relationship, volunteers and participants connected through one to four weekly phone calls aimed at easing participants' isolation. The SCP volunteers were trained in trauma-informed care and one-to-one meetings, which is a foundational practice of relational organizing. The volunteers documented the social pressures that their community partners shared during the calls to guide future community organizing efforts. The SCP project brought together the Metropolitan Alliance for Common Good, a Portland-based community organizing alliance; the Oregon Health & Science University (OHSU) School of Medicine; and a group of community-based behavioral health clinicians.

Missoula

In early 2020, Common Good Missoula (CGM) launched plans to bring relational organizing into public health and health spaces in partnership with six organizations: Missoula Interfaith Collaborative, Partnership Health Center, All Nations Health Center, Missoula Food Bank and Community Center, North Missoula Community Development Corp., and the Missoula City-County Health Department. As the pandemic unfolded, the effort shifted, with organizers focusing on neighborhood-level outreach and facilitating grassroots mutual aid, as well as bringing

community members into discussions with the city and county agencies responding to the pandemic. Through these efforts, CGM was in weekly contact with 3,000 Missoulians and was understanding emerging challenges in real time.

The Study: An Overview

Our rapid research study drew on traditions of participatory research[13] and realist evaluation.[14] Our data comes from interviews with 16 key participants: six community members/volunteer organizers, seven organizers who were paid for their (full- or part-time) organizing efforts, and three partners in health care and public health services. We also drew data from a Ripple Effects Mapping (REM) exercise with our sense-making team, which included five interviewees and five other people: an "outside" researcher sociologist, organizers from each site, and an organizer from IAF-NW, a regional IAF network of broad-based community alliances. REM uses appreciative enquiry, radiant thinking, and participatory, iterative methods to identify a project's diverse impacts as seen and experienced by people involved in the work.[15] Our 10-person sense-making team met four times to review interview data and collectively develop the findings that we present here.

Setting and Expanding the Table

In relational organizing practice, the table indicates a focus area that community members are motivated to explore, such as a "housing table." Similarly, local governments and other sector partners often use (perhaps overuse!) the term *table* to refer to a group assembled to work on a specific issue. For example, for our report, city-county agencies in Missoula convened a "reopening table" to make plans for reopening businesses and services after the initial pandemic shutdown. The table metaphor also calls to mind common idioms — such as setting the table for oneself and for guests, being invited to the table, and even being seated at the kids' table as opposed to the adults' table. In this chapter, we are merely setting the table; the full meal of further research and practice is still being prepared.

Findings

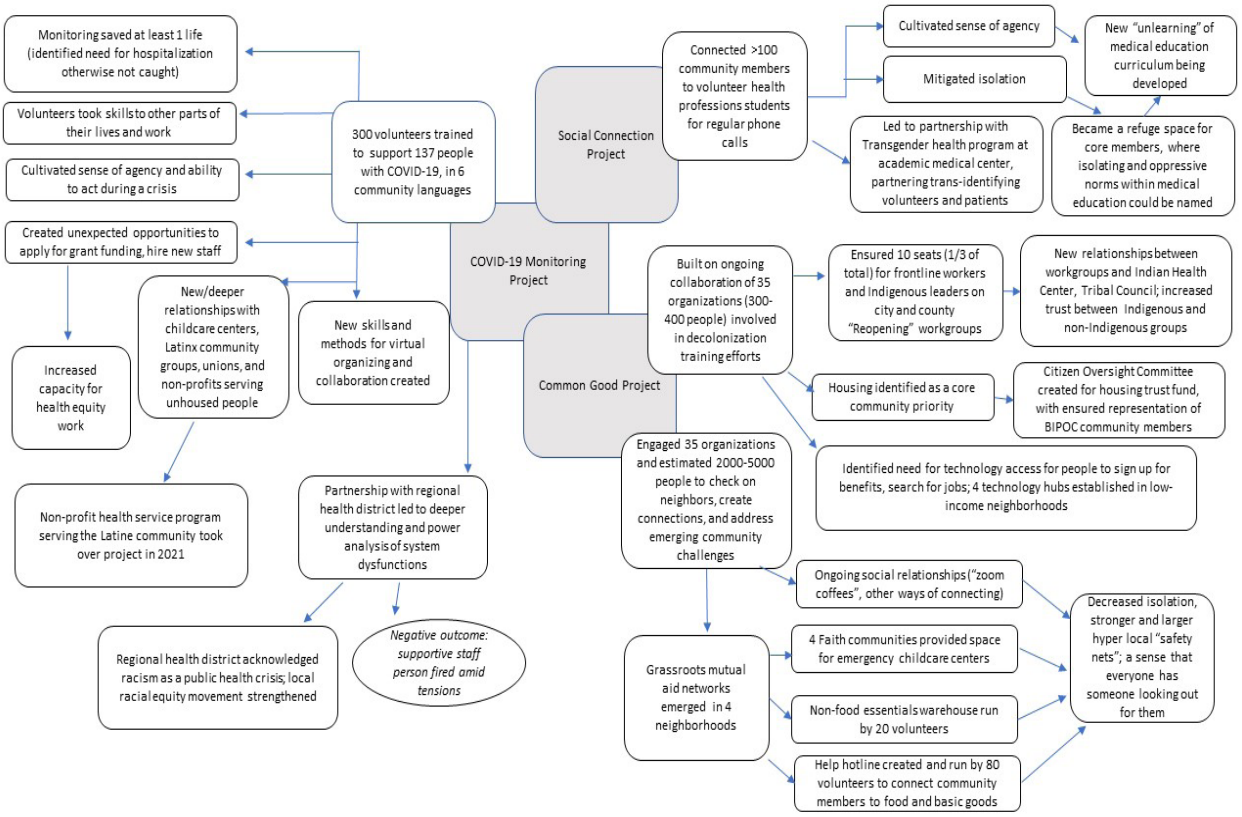
Our findings document outcomes from the projects that participants felt were made possible at least in part by the relational organizing approach underlying the work. These project outcomes are mapped in Figure 1. Our findings also describe *how* relational organizing contributed to the alignment between groups that was key to success. Our analysis identified that relational organizing contributed critically by enabling (1) rapid engagement, (2) speedy responses, (3) the building of trust, (4) the recognition of power dynamics, and (5) the centering of community needs. These central ideas are explored in the subsections below.

Rapid Engagement

Finding 1: Relational organizing was able to rapidly engage communities in crisis response.

Relational organizing's core skills, practices, and underlying model were able to mobilize hundreds of people quickly to respond to the COVID-19 crisis. Each project built on the foundational relationships between community leaders and organizations in the IAF affiliates. Community members engaged deeply and stayed involved through the pandemic year, finding connection, purpose, and agency while also uncovering and sharing information with health and other service partners that otherwise may not have been found. Figure 1 shows details of the mobilization's scope, direction, and impacts.

Figure 1. Ripple Effects Map of the Rapid Engagement Effort



At all three sites, the organizing efforts reached out to and engaged local community-based public health, health care, and social service organizations — not the other way around. Indeed, robust relational organizing projects can ensure more equitable community participation in policy alignment because they depend less on sector agencies extending an invitation. One public health partner characterized the importance of the project as follows:

> **I think that's one of the things that [the project] made the agency more aware of, that you do have a community organizing group that can really help those marginalized populations have voices. And when they have voices, things**

get done. And I think this is one of those moments in our history where we're not willing to sit back and watch [because then] all we're doing is just perpetuating the problems we've been dealing with for decades, if not longer. … The crisis begets the opportunity for public health and community advocacy to work in parallel.

Speedy Response

Finding 2: Relational organizing has a long-term time horizon of building relational power in the community. To the extent that such power has been developed, organizers can respond and mobilize quickly for specific crises and situations.

When the pandemic struck, it was the existing relationships — born of community organizing efforts "in between" crises — that allowed projects, their various partners, and community members to mobilize quickly in various ways (see Figure 1). Further, new relationships were built with community members as, in the pandemic context, many people recognized the importance of mutual aid and hyperlocal support networks. In contrast, it was often challenging to establish new relationships with health and public health partners, who were often strained to their limits by the pandemic.

To some extent, the organizing projects at all three sites initially stepped into some type of service delivery, such as monitoring people for COVID symptoms, providing emergency food or child care, or ensuring that vulnerable patients (as identified by a health care provider) had the necessary support. These volunteer, community-powered responses were structurally embedded in or adjacent to health care and public health programs through the organizing relationships, which factored into their success. While responding to the pandemic's service needs, the projects continued deepening relationships and inviting community members in to develop their own solutions. The organizing approach emphasized to participants the empowering aspects of taking action. One participant reflected on this as follows:

> I think the most effective thing was giving people a way to act at a time when it felt really scary and overwhelming. … We had probably about 100 people who were active volunteers. I think it helped get people unstuck from this place of flight-fright-freeze, like 'I don't know what to do.' … 'I don't know how to act in this moment.' … We did some really good things with the patients that we helped, but I think that, in the bigger picture, [providing opportunities to act] might have been its best contribution. … It's reminding people, like, 'You have a choice to act or not; you can be an agent in your community; you can be creative; you can use what is at your disposal to care for the people around you and to be part of something bigger than yourself.' And I think that was really valuable.

Several participants observed that service organizations sometimes had a hard time shifting their mindset to change their program offerings during the crisis; one participant described this as follows:

> So often, agency people were still in that moment just focused on keeping their agencies running … just keeping the doors open. They were, you know, responding to the governor's orders. … We were coming together to think about what do people need? But so many of those [service] people … were not talking to their [community] people. … They were just running their programs.

When relationship itself is the agenda, as it is for relational organizers, it cultivates a flexible attitude that can be especially useful in moments of crisis. It also helps service providers align around listening to people to hear what community members need in pivotal moments. Public health, health care, and service organizations eager to cocreate health and to shift away from transactional relationship models with community members may find skilled teachers and partners in building these long-term relationships with organizing projects.

Trust Building

Finding 3: Relational organizing skills are effective for building trust with community members and for creating space for authentic and productive dialogue with organizational partners

Relational organizing skills include active listening, acknowledging vulnerability, creating spaces where people feel able to be "real" with each other, and paying attention to the interests of different groups and individuals before focusing on mutual self-interest.

Relational organizers receive intense and ongoing training; they have either a six-day immersive training workshop or regular monthly hours through Health Equity Circles, along with regular mentorship from IAF-NW staff. Critically, the practice of relational organizing devotes time and reflection to honing these skills, receiving feedback on them, and learning to pay attention to the nuances of power and privilege in how these skills can be accessed. Participants talked at length about using these skills with community members, but they also identified ways in which these skills were actively used with health, public health, and service sector partners. One participant described using those communication skills as follows:

> **I think that those skills ... I think it goes back to listening, right, and active listening where you're listening to understand, not just to respond. … Agencies are nervous, or people can be nervous and, you know, don't wanna be exposed for there being a mistake that was made and they're nervous. Or how they're responding, maybe they know that they're not responding to the people most in need. And oftentimes, I was presenting stories or experiences that [were] coming into conflict with what people were wanting to do, but I think people were often surprised at how much I would just listen and be, like, 'Yeah, I hear what you're talking about. Probably, that makes a lot of sense to me. I see why you're choosing to do that right now.' … So even though I was bringing stories that … might have maybe created some tension, I could help them realize that there's a working relationship that we're trying to have here, because we both want to be providing not just services, but**

opportunities that will benefit them all and that will allow them to be healthy in this moment. And so I think … being able to be compassionate … can help keep those relationships alive.

[The] vulnerability that I think it takes to say, you know, 'Personally, I'm driven by this, and professionally I'm under this pressure from my organization.' Or — and not, like, airing dirty laundry but … just showing up as a human in your professional role, not a robot, as well, you know, and that just creates much more effective and honest professional partnerships. And people feel committed to you, not just the meeting on their calendar or the organization that you work for. You know, you've built a real … trusting relationship in a professional space. So I will always credit community organizing for that [be] cause I don't think I approached those kinds of professional relationships that way before. And I've noticed it had a sincere change in our — just the way our meetings go and who shows up and the equality of energy that they're able to bring.

Less positively, participants also described sometimes feeling that partner organizations weren't open to adopting these kinds of practices, either because they were averse to change generally or because the practices challenged cultural norms of (invulnerable) leadership and professionalism, transactional or short-term relationships, and limited communication or transparency outside of one's own organization. This sometimes left participants feeling frustrated and less effective.

Nonetheless, relational organizing offers new norms of communication that can swing the professional relationship paradigms from transactional toward relational. This frame shift of paying attention to the who and why of multisectoral partnerships — rather than only the what — is unique in its focus on trust as a requisite foundation for organizational partnerships. The skills required to make this shift may overcome some barriers to authentic alignment in current organizational cultures.

Recognizing Power Dynamics

Finding 4: For relational organizing, alignment isn't always the goal —there also must be a recognition of the differential power dynamics in society and organizations created by historic systems of oppression. This can come out as tension over power or control, or it can lead to growth in relationships with partners.

Participants often noted that getting all the groups involved in COVID-19 response to align around a common purpose was not always the goal of their projects; that is, it was not their work to get everyone to agree. Organizers felt that before alignment could be achieved, groups had to first recognize community leaders as genuine and equal partners. When officials with formal power asked community members to trust their judgment and good intentions, community members insisted on being included in decision-making. This provided a challenge: to respect community leaders' capacity and potential for a deeper alignment as equals. Some organizers and community members saw these tensions as opportunities to move away from defensiveness and conflict-avoidance (sometimes aligned with white fragility) and into deeper relationships in which partners recognize that being asked to do things differently is an invitation into trust.

One implication of these complex trust dynamics is that the skills of relational organizing can help collaborating individuals have productive conversations that pinpoint where they are in alignment and where their different interests make conflicting viewpoints understandable. One organizer shared a practical example of this skill at work:

> **We [the coalition of service organizations] were treating everything with, like, a broad sweep and talking about everything in such generalizations until one day, you know, I [said] …, 'I think people are at this table for different reasons. And until we understand what the public/private/self-interest is of not only the organization but that particular representative at the table, we're not going to be able to facilitate an effective and honest meeting … and have people come back or have people feel truly committed, because they're not [being] seen or given the space to share what's … important for them**

> **personally or what's important for the population they serve or work with.' … And once we started [understanding each other's interests] we found … that it helps us to create more effective agendas where we're speaking to the pieces that are most important and impactful for organizations and how they wanna work with their communities. … Those are some of the skills that I now feel confident in modeling at those tables.**

Centering Community Needs

Finding 5: Relational organizing engaged community members in authentic conversations and efforts to center their needs. Depending on the needs expressed, the efforts encountered different levels of resistance from existing power structures.

As the projects evolved, the local context and the needs expressed by community participants began to shape each site's specific response. As the ripple effects map in Figure 1 showed, this led to unique outcomes and program focal points; it also highlighted how sector partners responded to power-sharing in different ways.

In Portland, the project's initial focus on decreasing isolation easily aligned with an existing quasi-clinical concern of health care partners and met with no opposition — but also little investment of outside resources. In Spokane, where the organizing project played a similar role in supporting public health systems to monitor COVID-19–positive community members, project organizers found that as the crisis lengthened, the professionalization of pandemic responses led to their efforts sometimes not being prioritized by partners within health systems, even as community support needs increased. Further, subsequent involvement of the Spokane Alliance in highlighting the role of structural racism in health was met with opposition from some SRHD leaders.

In Missoula, clinical demands of responding to the pandemic limited organizers' access to working with clinical and public health staff. As a result, the project team decided to move out of health care (clinical and public health) spaces and into traditional community organizing arenas. These efforts ultimately focused on housing and worker protections that came to the fore during the pandemic. While these projects had many successes — including being present and involved

in the "tables" the city set — relationships were strained, and organizers were often told and felt that their priorities and demands were unrealistic.

This finding echoes the Framework for Aligning Sectors' recognition that power dynamics strongly shape how community voices can be present in any process seeking alignment. Projects that bring a relational organizing perspective into these alignment efforts are likely to push for power dynamics to be openly acknowledged and addressed. While this can be uncomfortable for sector partners, it sets a more expansive table for community voices, as one participant reflected:

> **I feel like … that idea of empowerment is such a core thing of all of this, and such an impossible thing to figure out how to do successfully. … People have tried community advisory boards, and that seems to work in a certain sense, but feels disingenuous as far as, are we actually listening to folks or just giving them a place to sit while other people make decisions? And that gets frustrating, at times, I think. … Discomfort in relinquishing power, I think, is a really hard thing — but that seems like the best way to do things.**

Creating a Space for Community Power

Finding 6: Relational organizing creates vehicles for people to recognize and exercise their power, both individually and collectively, to make decisions and advance their priorities. In the language of the Framework for Aligning Sectors, it brings more and richer community voices into the process of setting shared goals and metrics for community health.

Relational organizing is not a one-size-fits-all remedy to community or individual empowerment. Each project encountered difficulties in supporting community members to be active participants in decision-making: It was often challenging to get community members into the spaces where policies get made, and when they were there, different attitudes toward power-sharing sometimes meant that they were present but not fully listened to. Even with these caveats, we found common and powerful narratives of relational organizing enhancing people's skills and changing their attitudes so that they could raise their voices more effectively, and more collectively,

about the health and social issues that mattered to them. For participants who experienced issues related to racial or ethnic identity, class or income status, or past dehumanizing experiences such as incarceration, relational organizing often proved an especially powerful experience of connection and empowerment, as these comments show:

> I think, in my first relational meeting with [the project organizer], I told him, 'I don't think racism is ever going to end, and I've accepted that reality.' … I'm a pessimist by heart. But I think learning community organizing … helped me, kind of, work myself out of that mentality and learn that things can change. And I've seen it happen. You know, I've seen those examples. I've seen how people can show up for each other.

> Being involved in the criminal justice system, you lose a lot of your power. … Who you are as a human kinda gets, I would say lost, you know? And so as I started getting involved with community organizing, I really felt a sense of power back. … I know I have a voice now, and it's not about fighting back. It's about trying to reclaim or relearn, you know, stuff that I guess people that aren't in the justice system take for granted. … Organizing for me has given me the ability to regain my voice and power.

> Power does exist, right? Like, a landlord has power over their tenants, or health insurance companies have power over, you know, the people that are their clients. And those power structures exist. And a lot of those things are really hard to navigate as just a human being, and so, community organizing is, like, such a great opportunity for an individual or an ordinary person just to, like, come together and build power with one another and have the things that they really care about be heard by the community. … So, what excites me is people recognizing their own power and being able to, like, talk to decision-makers or have a voice within the issues that are really affecting them with, like, the genuine belief that they can make a change. … It's just

allowing ordinary people to become leaders within their community, and that's really exciting.

Discussion and Conclusions

Our findings contribute to a growing body of evidence that relationships are key for both emergency short-term change and long-term change. Other research conducted on community organizing for health during the pandemic has found some similar themes,[6] such as that projects frequently pivoted toward mutual aid efforts to meet acute pandemic needs, while still building long-term power, and that there is a strong perception that existing relationships with community members were what made rapid pandemic responses by organizations possible.

Although our study's time frame is short, our program participants' observations concur with a recent evidence review, which showed that more intense, active strategies of community inclusion — such as relational organizing — are more often linked to sustained positive change than more passive inclusion strategies.[12] These active strategies often require more resources and demand more from community members,[12] which means that partner organizations must be ready to provide funds, training, and support as needed to make such partnerships genuine and successful. For community organizations interested in reflecting on and effectively sharing their work's diverse impacts, we recommend using REM. It is especially helpful in cases (such as ours) where outcomes of interest change and deepen over time.

Finally, participants shared important topics that we have not covered here, including how relational organizing helps build alternatives to the individualizing impulse so common in American culture. There's much more to explore about the unique experiences and challenges of organizing in the health care context and about what organizers learned that could be effective for creating community in these spaces. As we noted, relational organizing relies in part on the ties within a space that give people a sense of shared identity and of "we're in this together," which is not the case in most health care settings.

Our work together as a research team does not end with this report, nor does the work of the three organizing projects. Presentations of these findings back to the community partners will invite reflection and identify which research questions our partners want to pursue next. Our sites

will continue to collaborate and to build both an evidence base and a set of practices to strengthen relational organizing as a tool for community leadership in health. The core components of the Framework for Aligning Sectors provide useful signposts to guide some of these future efforts. Indeed, relational organizing's multiple strengths for centering community voices to guide health policy can help set shared purpose, priority metrics, and governance practices, while the skills of relational organizers can prepare people in positions of traditional power in health, public health, and service sectors to listen, open up to vulnerability, and be honest about self-interest in ways that will lead to more genuine alignment. These are themes that our research will continue to investigate as the work of the projects continues.

As the map in Figure 1 shows, these projects had direct impacts on the health and well-being of hundreds of people who participated in them. The project ripples extend in many directions and bear on some of the most grievous and necessary challenges to address: building new trust and decolonizing relationships with indigenous nations, raising community voices against structural racism, and dismantling assumptions of medical and health care culture that isolate us from each other and from the care we all deserve. Such challenges can overwhelm us, especially when we are isolated. Relational organizing contributes to the solutions and, importantly, brings us collective support and even joy in our search for community-powered solutions — a search and process that, as we noted at the beginning, is not the preamble to the work, but the work itself of creating a healthier and more just society.

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Community Resilience for COVID-19 and Beyond: Integrating Health and Social Services in Contra Costa County

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Cross-sector alignment among health care, public health, and social service sectors shows promise for promoting both population health and efficient use of resources.[1,2,3] However, we lack evidence about how investments in cross-sector alignment may support organizational and community resilience during crises such as the COVID-19 pandemic. In keeping with current work, we define *resilience* as the ability of organizations and communities to adapt, maintain functioning, and thrive in the face of adversity.[4,5] For managers and policymakers, understanding the range of potential consequences of cross-sector alignment — including how it impacts communities during a crisis — is essential. We therefore sought to characterize how pre-existing efforts to align health care, public health, and social services in Contra Costa County, Calif., were used and adapted over the course of the COVID-19 pandemic.

Advanced Alignment in Contra Costa County

Deep alignment among health care, public health, and social service systems remains relatively rare.[6] We set our study in Contra Costa County because it offers an example of what Aligning Systems for Health defines as *advanced alignment*[7] — that is, organizations that provide health care, public health, and social services, and that share systems in the four key areas of purpose, governance, financing, and data. In Contra Costa County, major service providers across all three systems are part of the county government. The county health department, Contra Costa Health Services, encompasses the county's safety net hospital and a network of 10 primary care clinics, as well as public health services and the Medicaid managed care plan that insures nearly 90% of the county's approximately 250,000 Medicaid beneficiaries. Social services are administered by a county government sister unit: the Employment and Human Services Department. Thus, while distinct units of county administration take responsibility for safety net health care, public health, Medicaid insurance, and social services, these units ultimately report to a *common governance* body (the county board of supervisors).

Further, since 2016, a $200 million investment through California's Whole Person Care Medicaid waiver program[8] has supported the county in forging stronger links between health services and social services for the *shared purpose* of improving care for the county's Medicaid beneficiaries. Called CommunityConnect, this initiative provided additional *shared financing*

for services across the health and social service sectors, as well as support for new data sharing infrastructure. At the core of CommunityConnect is a large-scale social needs case management program, housed in the public health department, that coordinates care to meet the physical, mental, behavioral, and social needs of individual patients. The program has capacity to serve 12,000 patients at a time and offers each patient 12 months of case management.

In this chapter, we analyze how components of Contra Costa County's aligned systems supported resilience during pandemic response by strengthening the county's ability to adapt and maintain functioning.

Methods

We chose an in-depth qualitative study design to illuminate how Contra Costa County's prior work to align systems across health care, public health, and social services supported its pandemic response. At the time of our study, CommunityConnect represented the focal point of the county's system alignment efforts. Accordingly, we focused our data collection on CommunityConnect. We conducted semistructured phone interviews with a total of 31 informants, 14 of whom occupied managerial roles in public health, health care, or social services, and 17 of whom were social needs case managers who coordinated services across these sectors directly on behalf of patients. Two of our team members conducted the interviews, which lasted 30–60 minutes, between October 2020 and May 2021. All interviews were audio-recorded, transcribed, and entered into NVivo software to facilitate analysis.

We used an inductive-deductive qualitative coding approach to systematically identify recurrent themes across transcripts. All transcripts were coded by at least two team members. We subsequently revised our initial code list — which was structured around key components of the research question — to capture new ideas and combine redundant codes. Our methods were approved by the University of California, Berkeley's Institutional Review Board.

Results

We identified four distinct components of the county's system alignment capabilities that supported resilience during COVID-19:

- An organizational culture of adaptability, fostered by the CommunityConnect unit
- Management processes for population monitoring and outreach
- Front-line staff with flexible skills to support health and social care
- Trusting relationships among organizations

We now explain each of these four components, with illustrative quotes from our interviews.

Adaptable Organizational Culture

Over the four years preceding the pandemic (2016–2020), the county had rapidly scaled up the CommunityConnect case management program. This ambitious program, which was housed in the public health department, was at the core of the county's system alignment efforts. To deliver CommunityConnect, the county created a new organizational unit, which developed an organizational culture of adaptability and speed — two traits that proved necessary to success when developing a new, multidisciplinary care model in an accelerated timeframe. When the pandemic hit, the capacity for and comfort with adaptability shared by CommunityConnect staff, particularly at the management level, closely matched the tasks required to scale up emergency public health services. The public health department redeployed many of the CommunityConnect staff members to manage the scale-up to mass COVID-19 testing and contact tracing. One administrator noted that established CommunityConnect teams worked together on pandemic response, allowing the culture of adaptability (i.e., group norms) to transfer to these new assignments:

> **All these people who have been getting CommunityConnect up and running were able to quickly shift and use their skills and use their already established teams in Connect, working together for this past year [of the pandemic], which gave them, I think, a real dexterity that wouldn't have been**

> there at all, for us at least, if we hadn't been through the last four years of CommunityConnect. —Administrator 12

Another administrator explained that the demands of creating CommunityConnect — specifically, the demands for speed and flexibility — had prepared the organization to work quickly, at scale, and under uncertainty during pandemic response:

> We had to hire, like, 100 people in several months to get CommunityConnect started. That was a real learning curve from CommunityConnect. We had already learned a lot about how you do things relatively quickly to bring things to scale. …. And a lot of what we did in CommunityConnect was really listening to the clients and then changing our program. —Administrator 3

An administrator who had been involved in CommunityConnect and then managed elements of the public health department's pandemic response emphasized that CommunityConnect had recruited staff prepared to lead new programs amid uncertainty, which again are the same skills needed in pandemic response:

> I come from a vein, again, of a startup world — nothing is ever perfect. And, you know, it's just, you just got to jump in and do it. Like, just get it started and you'll figure[it] out, and you'll make mistakes, and you'll make tweaks. —Administrator 2

Managing Population Monitoring and Outreach

In addition to supplying teams poised to adapt to new challenges, the county's work to align systems also provided pre-existing technical and management processes for population-scale monitoring and outreach. These technical processes benefitted from an integrated data warehouse and a team that linked records for a substantial proportion of the county's economically vulnerable population, integrating electronic health records, Medicaid claims, social service benefits, and data from other county-administered systems. This data warehouse had been built through a multiyear process. This process included working out data sharing agreements among relevant health care and social service organizations in the county, as well as inventing systems and tailoring them to the needs of stakeholders.

During the pandemic, the integrated data system and the management processes developed to use it were repurposed for COVID-19 response. Early in the pandemic, for example, the data scientists who had created a predictive risk model to determine patients' eligibility for social needs case management created a COVID vulnerability index to identify county residents at high risk of poor COVID outcomes. Individuals with high COVID vulnerability index scores were assigned to case managers, who called those individuals to offer assistance with sheltering in place. These case managers used electronic health record–based workflows established for CommunityConnect case management prior to the pandemic. These processes, which had been developed for CommunityConnect, gave the county generalized capabilities to proactively reach out to vulnerable population members, as one administrator noted:

> **From the technical perspective, we had developed a system that you could throw anything at. You know? It doesn't matter if it's a system that supports patients with their social needs or as they need services to respond to COVID, or it could be, really, anything else. —Administrator 6**

Another administrator emphasized how crucial it was to have both the technical systems and the management processes built prior to the pandemic emergency, which let them quickly deploy these resources for new purposes:

> **COVID, you know, caught us by surprise. And we had no time to … build all this infrastructure. So, the fact that we had it all built, it didn't, you know, require 10 days of us meeting, [but instead] we were actually making phone calls and helping people with their food needs and transportation needs and trying to keep them safe at home. … It only happened because of the infrastructure that was in place because of CommunityConnect. —Administrator 4**

When the pandemic required the county's public health department to create new information systems to deliver COVID test results to county residents, they were able to build on pre-existing processes that had been developed for CommunityConnect, again saving time. A county public health department administrator characterized this as follows:

> We do all of our [COVID] testing, we do all of the notifications via text to the clients that come in so they get their results instantaneously. As soon as we know it, they know it. So, we had to build all those systems. And I think CommunityConnect was the place that really showed us how we could do those things quickly and respond. —Administrator 3

Flexible Front-Line Support Staff

To build the CommunityConnect case management program, the county had assembled a large staff of more than 100 front-line case managers with training and experience to coordinate care across sectors for individual patients. This workforce proved particularly valuable for the county's COVID-19 response. The CommunityConnect program continued to support thousands of low-income individuals to navigate both health and social challenges throughout the pandemic. Case managers provided expanded interpersonal counseling and social support during the pandemic to assist patients who were isolated and worried, as well as assisting with elevated needs for access to unemployment benefits, emergency housing, child care, and food assistance. Case managers routinely emphasized that they also met increased needs for social connection; one case manager described this as follows:

> A lot of people just wanted to talk to me. They didn't want to be referred to behavioral health … they just wanted to talk to someone. —Case Manager 41

Case managers also described how their system navigation work changed to meet increased patient needs during the pandemic, while they were also helping patients navigate a changing landscape of assistance resources:

> During this pandemic it's been really helpful to just show up for patients … just providing a safe space for people to talk about what they're going through and then also that tangible, 'Here's where you can go get food; Safeway is hiring right now' — that kind of information where we're actually providing resources that directly impact their well-being. —Case Manager 4

In addition to continuing to manage social needs cases, the case managers were also redeployed to various pandemic response roles, such as contract tracing for individuals with positive COVID-19 test results. Interviewees noted that the case manager workforce was uniquely suited for these emergency positions:

> **Well, [CommunityConnect] gave us a bunch of people who could reach out to patients and address their individual needs. It gave us a workforce to help staff the new branches that we created as far as the COVID response. So, it was almost like the emergency workforce was right there until we can hire all these other temporary emergency workers, which just takes time. —Administrator 1**

Trusting Relationships

Efforts to align county systems over multiple years, with CommunityConnect as the most recent focal point, accumulated a history of collaboration among organizations providing health care, public health, and social services in the county. Positive experiences had built up habits of cross-sector cooperation, which supported the COVID response. For example, one interviewee observed that prior relationships formed through CommunityConnect had been critical in shifting from a homeless services role with CommunityConnect to a new role organizing the county's program for housing homeless individuals in hotels as part of the COVID emergency response:

> **I can't imagine if it was somebody that didn't have the connections like I do … because I already had those relationships built with our Health, Housing and Homeless Division, who really manages all those hotels and the logistics of the hotels, as well as our Healthcare for the Homeless team. —Administrator 11**

Another administrator explained that relationships and work processes developed between the public health department and social services departments through CommunityConnect allowed department managers to streamline their work with common patients/clients during the pandemic:

> **[The social services division] would send us lists of high-risk patients that they were being mandated to reach out to by the state, and we were able to quickly cross reference and say, 'Oh, well, 60% are on our list already, so we'll take care of it, so you guys only need to call, you know, these 400.' So, that worked out great to save resources on both sides. —Administrator 7**

Trust, information sharing, and collaboration were generally described as positive across providers in both county government and community-based organizations. However, community-based organizations did express some dissatisfaction that the influx of Medicaid waiver funding for system alignment over the preceding five years had initially been concentrated within the county administration — to build up CommunityConnect — rather than being distributed across a broader range of organizations.

Discussion

As our findings show, when the COVID-19 pandemic arose, prior investments in aligning systems in Contra Costa County provided multiple, unanticipated benefits for organizational and community resilience and facilitated emergency responses. While prior work has identified the key areas — purpose, governance, financing, and data[9] — that communities need to consider when aligning across health care, social services, and public health, our analysis highlights opportunities that emerge as a consequence of alignment. Given the significant investment required to align systems, it is important for decision-makers to understand the full range of benefits that can result from this time-consuming and resource-intensive effort.

In analyzing how one aligned system supported resilience by facilitating pandemic response, we identified four components enabled by prior system alignment that were repurposed for unanticipated pandemic requirements. One notable feature of this county's efforts at system alignment was its culmination in a large, new organizational unit (CommunityConnect) dedicated to linking care across health care, social service, and public health systems. Public administration theory suggests that stand-alone integrator organizations can represent an advanced form of cross-sector networking.[10] Most of the benefits we document for pandemic response were promoted

by the establishment of CommunityConnect as a distinct organizational unit that was large and well-resourced enough to develop specialized alignment support capacities. For example, CommunityConnect fostered a culture of adaptability among its approximately 150 staff members because that quality suited the organization's primary task. Further, CommunityConnect's status as a distinct unit facilitated its establishment of management processes for population monitoring and outreach, as well as a cadre of front-line staff with skills to support health and social care. These findings suggest that establishing a strong lead organization or department can help solidify system alignment capabilities. Additional research is needed to understand and compare concentrated and distributed leadership models and how each suits different circumstances and alignment stages.

Studies of organizational resilience find that resilience to crises and resilience to routine challenges typically rely on similar organizational capacities and processes.[11] Because alignment forges new ways of working, we can view processes to align systems across health care, social services, and public health as striving to enhance resilience to routine challenges, which makes these efforts applicable to less routine crisis events.

Our study should be interpreted in light of several limitations. First, our data collection focused on identifying components of system alignment that were involved in pandemic response. We did not strive to identify components that were uninvolved in or inhibited pandemic response, although we did not hear of any ways in which alignment did inhibit response. Second, our study focused on alignment efforts that had been led by the county government and pandemic response activities organized by the county public health department. Although our interviews included individuals working in nonprofit community organizations as well, we did not comprehensively collect data on activities that did not involve the county administrative structures.

Conclusion

We have identified specific ways that long-term, substantial investments in cross-sector alignment translated into enhanced response capabilities during the COVID-19 pandemic. This is not intended as a generalizable example that could be implemented immediately in most locations, but rather as an example of potential benefits from persistence across many years, and an opportunity to investigate, in detail, what happens when high levels of system alignment are reached. While a

more prevalent scenario is localities with limited alignment and little momentum for change, our work documents why decision-makers in these places may want to invest in change.

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Chapter Two

Measuring Aligning

The Aligning Systems for Health initiative is focused on how cross-sector collaboratives can better meet communities' goals and needs. There is a recognized gap in understanding how these systems can be built and measured for that purpose and the efficacy of the organizational shifts that collaboration requires. A cohort of grantees were funded under the initiative to study how collaboratives are measuring their processes and outcomes. Grants were funded for a total of $300,000 across four 9 to 12-month projects. The grantees were located across the nation in New Jersey, Massachusetts, Ohio, and California. The awarded organizations, Camden Coalition, John Snow Institute, Kent State University, and the Public Health Institute, each examined different aspects of measurement practices within collaboratives. Findings indicated the importance of measuring equity in these contexts and identified effective ways to measure the process of aligning across sectors. Additional findings from each of the grantees can be found in this chapter.

Rethinking Value: The Benefits of Cross-Sector Collaboratives Serving Populations With Complex Health and Social Needs

Camden Coalition

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At the Camden Coalition of Healthcare Providers' National Center for Complex Health and Social Needs, the focus is on complex care — that is, on serving people whose combined medical, behavioral health, and social challenges result in high health care utilization and poor outcomes.[1] Because people requiring complex care have diverse needs, services for this community are best delivered through cross-sector collaborations.

Our research sought to better understand how the value of cross-sector collaboration is defined and measured by different organizations and community members. In describing our work here, our goal is to strengthen how cross-sector collaborative initiatives are implemented and sustained in the complex care field.

Context

Cross-sector collaboration is a key step in improving health equity and addressing collective challenges facing health care, social sector, governmental, and public health organizations at the community level.[2,3,4] A cross-sector approach ensures that shared issues are addressed in a way that incorporates the feedback and expertise of diverse stakeholders. Cross-sector collaboration is particularly important in this time of value-based care, when organizations are increasingly accountable for the holistic well-being of their patients or clients. Given the limited data on this issue, we embarked on a qualitative research study to understand how organizations and community members participating in cross-sector collaboratives define and measure value.

The term value generally has financial connotations when applied to a project or program and often refers to a return-on-investment (ROI) or cost-savings potential. However, when considering the distinct cultural, operational, and funding contexts of participants collaborating across sectors, we lack a common understanding of three key questions:

- What makes these cross-sector partnerships valuable for organizations or their communities?
- Which measures demonstrate the "value" of collaborations?
- Is "value" solely financial in nature?

Further, cross-sector collaboration has long viewed meaningful community engagement as best practice, yet organizations nonetheless vary in how much they incorporate community voices into their programs and cross-sector collaboratives.[5] Without consistent community engagement in these projects, there is often a lack of understanding about what individuals and communities value in cross-sector collaboratives.

Methods

Our research team used a qualitative, grounded-theory, participatory approach for this project.[6] We chose this approach to support the discovery of abstract and subjective themes, as well as to support relationships associated with the value-creation concept in the context of diverse cross-sector collaborations.

We convened five key informant focus groups with the National Center's five Ecosystem Learning Collaborative sites and three focus groups with community members affiliated with the Learning Collaborative projects, including past and current program participants and community advisers.[7] The Learning Collaborative participants represented diverse sectors including health care, social services, county government, homeless services, behavioral health, and criminal justice. The community member advisers included current or previous patients, clients, and community members who have experienced significant health or social needs. Participation in focus groups was voluntary and was not connected to other Learning Collaborative activities.

Camden Coalition staff members moderated the focus groups. We applied a grounded theory method to capture participants' voices and emergent themes.[8] While the term *value* was central to our research questions and analysis, we avoided using it in interviews to avoid conveying any of our own preconceived notions to participants. Instead, we used words such as *benefit* and *impact* to better convey the concepts behind the term.

We shared preliminary findings back to focus group participants and incorporated their further feedback into our analysis. We provided gift cards to community focus group participants in recognition of their time. The research study was deemed Institutional Review Board–exempt.

Findings

The organizational and community member focus groups offered many different viewpoints on the value of cross-sector collaboration. Participants' responses often shifted according to role, reflecting individual, organizational, community, or collective perspectives. Across these perspectives, we identified four underlying dimensions that contributed to participants' understanding of value. Specifically, participants told us that cross-sector collaborations are valuable when they —

- *Provide intrinsic benefits* by aligning with shared personal and organizational purpose
- *Engage communities* to ground collaboratives in community members' priorities and insights
- *Demonstrate outcomes* that matter to organizations and communities
- Lead to sustained *system-level change*

Intrinsic Benefits

Cross-sector collaborations are valuable when they align with a shared purpose — that is, the missions, values, and beliefs that motivate individuals and organizations to action.

Focus group participants described the intrinsic benefits that individuals and organizations experience through their collaborative work. Moral and humanitarian motivations were a prominent theme, with participants in both the organizational and community focus groups highlighting the importance of alignment with personal and organizational mission or moral beliefs. For example, many organizational focus group participants noted that health disparities and inequities were an organizational priority and shared the view that individual organizations cannot address these upstream issues on their own:

> **From the health care perspective, we've known for years that health disparities and social inequities exist and have always approached every child with an equity lens. But sometimes it's really just been talk, and I think now**

> we're ready for action — and the only way a health care organization can do that is with community partnerships. They can't ever do it alone. —Hospital staff member

The cross-sector collaborations aligned with their sense of interdependence with community entities. Focus group participants also appreciated the experience of sharing information for innovation and best practices and said they found joy in participating in collaborative work to solve complex problems. Participants of the community member focus groups emphasized the importance of service and giving back both to other participants and to the community at large. They conveyed the sense that this giving back was therapeutic in and of itself, and that it enhanced a sense of self and finding purpose:

> I've always said that I wanted to do mentorship. I feel like everybody needs somebody to talk to, especially someone who's been there who understands what you're going through — the fears, the worries, the joys. I would just love to be that for somebody. —Community member

Community members also expressed a sense of duty and commitment to the organization where they received services.

Community Engagement

Cross-sector collaborations are valuable when they meaningfully engage community members and individuals who have lived experience in identifying needs, developing solutions, and sharing information.

Many organizational focus group participants noted the significant impact that community-level factors can have on individual health and well-being. Many health care and government organizations acknowledge this fact and are proactively engaging community institutions in their initiatives to both build trust and gain credibility. Much of this community engagement is aimed at better understanding the issues that lead to poor health outcomes and gaining buy-in for the resulting collaboration:

> **What I would like to see … is a solid relationship with our community partners to be able to understand what affects our patients, our members, our families so that we can better care for them — so we're not just spinning our wheels and focusing on what we know, but [focusing more on] what affects them in their own community. —Hospital staff member**

Community members had a similar perspective. However, organizational focus group participants had varying interaction levels with community members, depending on the sector. As a result, lived experience was incorporated into organizational work in some capacity, but the level was inconsistent across sectors. For example, community-based organizations were more likely to involve program consumers in the program design and implementation than other sectors.

By definition, community member focus group participants were willing to participate in organizational activities, and they all expressed a desire to give back to the organization that had helped them. They particularly appreciated seeing services or governance changes in response to the suggestions and feedback they brought in from their community's members:

> **We brought some information back to the [organization], and they actually used it and things started working. So now the program has grown, and it is just amazing how it does. Sometimes … you don't think what you're doing is really working. But you can see it. —Community member**

Community member focus group participants also reported that behavioral health, transportation, and housing are the most significant individual and community needs.

Outcomes

Cross-sector collaborations are valuable when they demonstrate multiple-level outcomes that community members and organizational participants see as a priority.

When discussing how they measure and demonstrate value to sustain, enhance, and expand collaboration, organizational focus group participants highlighted both the process and outcome

measures associated with a project's broad aims. Indeed, participants often described a process (e.g., completing a follow-up visit after hospitalization) as a beneficial outcome of cross-sector collaboration; given this, we use the term outcome here to cover processes as well. We also separate outcome measures into three interrelated categories: individual, organizational, and collaborative outcomes.

Individual Outcomes

Many organizational focus group participants provide direct services to individuals with complex health and social needs. These participants expressed a strong commitment to addressing individual needs, which is often demonstrated by working across organizations. Improving an individual's experience of care through techniques such as trauma-informed care was cited as a key outcome by participants working within community-based organizations, while focus group participants from health care organizations tended to track individual progress using clinical measures.

Participants of both types of focus groups highlighted the importance of long-term stability and recovery for individuals. For many, this meant ensuring that individuals were able to receive services in community-based settings rather than institutions such as hospitals or jails:

> **I think the exciting thing about the collaborative is getting those closer connections and more warm handoffs. So, it's not just a referral to your own Center, but it's actually working with partners to do a warm handoff.**
> **—Community-based organization member**

Organizational Outcomes

Our study found that organizational outcomes were typically the most well-defined outcomes and the most closely connected to the concept of value. Participants from all sectors in the organizational focus groups said their organization's motivation for participating in the collaborative was to broadly improve client outcomes. They also said that individual-level needs and supporting individual outcomes were often the organizational metrics of success, especially for organizations focused on serving populations with complex health and social needs.

Given the wide range of financial incentives and organizational structures, organizations often prioritized sector-specific outcomes. For the health care sector, such outcomes included shifting utilization to appropriate care settings and changes in population-level health indicators. Targeted outcomes in county government included shifting people from institutional services to community-based services, individual outcomes, and connection to benefits. For community-based organizations, key outcomes included streamlining processes and improving individual outcomes.

Collaborative Outcomes

We define *collaborative outcomes* as shared measures across organizations that demonstrate the collaborative's impact. In general, the various collaboratives highlighted broad goals; their focus was typically on creating solutions to meet the needs of high-risk populations in the short term while also addressing long-term, systemic barriers to improved outcomes:

> **One of the true value propositions that I was excited about from this collaborative is for us to collectively come together and identify what are those data elements that we would like to begin to capture [and] to measure the interventions that the collaborative is driving toward. —Community-based organization member**

We found that organizations were willing to commence collective work without clearly defined and measurable outcomes, and without sustainable funding sources (see Table 1). During focus group discussions, organizational participants began identifying other potential outcomes such as a systemic solution and responsive network to address problems and meet long-term needs; improved referrals, warm handoffs, and authentic community engagement; exchange of best practices and resources; and improved trust between organizations.

Table 1. Views on Funding and Sustainability Based on Sector

Health Care	County Government	Community-Based organizations
Participants from health care organizations were more likely to raise value-based payment, capitation, and potential cost savings to their organizations.	Participants from county government discussed the need to fund their participation in the collaborative, as well as the hope for long-term cost savings.	Participants from community-based organizations highlighted the need for funding but rarely mentioned the concept of an ROI or cost savings. Sustainability was often framed in terms of long-term outcomes and ongoing collaboration.

Sustainable System-Level Change

Cross-sector collaborations are valuable when they lead to sustained improvements for individuals with complex health and social needs.

Participants in both focus groups expressed significant frustration over the current state of care for individuals with complex needs because it results in poor outcomes for organizations and individuals. Organizational focus group participants felt that relationships, communication channels, and codeveloped solutions between organizations were critical at the start of a collaboration to address systemic issues:

> **It still feels like at times that the mental health system doesn't know what to do with individuals, so they're looking to the criminal justice system to deal with some of the struggles. [This] is not where individuals with serious mental illness belong. They shouldn't have to access the criminal justice system in order to get treatment. —County government participant**

Participants in the organizational focus groups highlighted program sustainability as another important aspect of long-term, system-level change. In this case, sustainability includes

the necessary financial and organizational support, as well as community participation to make a long-term community impact. Overall, organizational participants said that collaboration often was not reliably funded, and that existing funding tended to be short-term and limited in scope. In fact, collaborations were often seen as proof-of-concept projects that could result in future funding opportunities, yet the short-term outcomes were not always defined or agreed on in advance. Overall, organizational focus group participants said that sustained collaboration is necessary for a long-term change toward a more coordinated, holistic approach to care.

Discussion

The aim of our research study was to better understand how different organizations, community members, and individuals with lived experience can develop a shared concept of value — based on their diverse perspectives and experiences — that can strengthen the implementation and sustainability of current and future cross-sector collaborative initiatives. We acknowledge that our sample of research participants is limited. All participating individuals and organizations are part of a national, cross-sector learning collaborative, and they are working in their respective communities on collaborative initiatives to better serve populations with complex health and social needs. This could limit the applicability of some of our conclusions and recommendations. Nonetheless, the following overarching themes of value creation that we identified are significant and should be considered in the planning, implementation, and evaluation of cross-sector collaborations.

Value Goes Beyond ROI

Value is not solely dependent on financial ROI. While the concept of value has traditionally been defined by financial outcomes, in this sample, participants perceived the collective benefit of cross-sector collaborations more holistically. This reinforces our findings that value is perceived as multidimensional, with each dimension holding varying levels of influence on organizations and individuals, depending on the internal and external contexts. This finding complements recent work on establishing the value case for complex care interventions by including nonfinancial metrics and indicators.[9] While participants certainly spoke of financial stability as important, they balanced

these concerns with other dimensions of value. Organizations rarely identified anticipated ROI or cost savings as a collaboration's primary benefit; instead, they highlighted a number of domains in which this value is expected or already realized.

Value Is Contextual

Value is multidimensional, contextual, and dependent on perspective. Focus group participants described multiple dimensions of cross-sector collaboration value, including intrinsic benefits, community engagement, multiple outcome levels, and sustainable system-level change. These dimensions represent factors that influence initial and long-term participation in collaborative efforts. They should not be considered as a checklist for collaboratives but rather as important considerations to sustain activities and demonstrate impact.

Value Involves Community

Value is created through meaningful community participation. Cross-sector collaborations need formal mechanisms to foster both the participation and the leadership of community members and individuals with lived experience. Communities benefit when collaborations address community members' needs and priorities, take clear actions, and give people opportunities to contribute to initiatives and give back to their communities. Capacity building, skill-development activities, and financial reimbursement can help equip community members to participate more fully in collaborative work.

Value Is Complex

Value is measured through multiple levels of interrelated outcomes. No single outcome can account for a collaboration's community impact. To quantify the impact of collaborative efforts across sectors requires that we consider a broad set of individual, organizational, and collaborative outcomes. Defining and identifying these diverse outcomes is often a key activity of emergent cross-sector collaborations, and it should be tailored to the context and priorities of the stakeholders and communities involved.

Conlusion

Cross-sector collaborations have the potential to make a significant impact on health and social inequities, especially for vulnerable populations with complex needs. Such collaborations are valuable when they align with individual and organizational purpose, meaningfully engage communities, demonstrate outcomes, and grow and sustain system-level change. However, aligning across sectors and building meaningful and lasting partnerships across organizations with different cultures, mandates, funding streams, and regulatory mechanisms is complicated and challenging. Developing a deeper, more nuanced understanding of how value is created from diverse perspectives, experiences, and contexts will improve how organizations implement these crucial initiatives.

Our findings show that defining value as primarily linked to financial considerations does not reflect the nuanced, holistic understanding of value that emerged from even this small sample of cross-sector collaboration participants. Across the full and diverse ecosystem of such collaboratives, we would expect understandings of value to be even richer and more dynamic. We therefore suggest that collaborative projects frame questions about value when they launch. These questions will create space for varied, holistic understandings to emerge about why cross-sector collaboration is important and beneficial to individuals, organizations, and communities. Table 2 shows examples of questions that organizations can use when working with diverse partners across the community to better understand priorities, motivations, and perspectives that contribute to notions of value.

Table 2. Questions to Ask to Better Understand Value Among Partners

Organizational stakeholders	Community members and individuals with lived experience
• Why did your organization make the decision to participate? • How will you know you're succeeding or failing as a collaborative? • What do community members tell you about how the collaborative impacts them? What opportunities do they have to contribute to its planning, implementation, and assessment?	• What do you think your community needs to be healthy and happy? • How well is the collaborative addressing community needs? What is working well and what is not? What do you look for to determine what is working and what is not? • How is the collaborative impacting you and others in your community? Who is benefitting and in what ways?

Ultimately, we will realize the full potential of cross-sector collaboration only when we understand and recognize its multidimensional, context- and perspective-dependent contributions to the people and communities involved.

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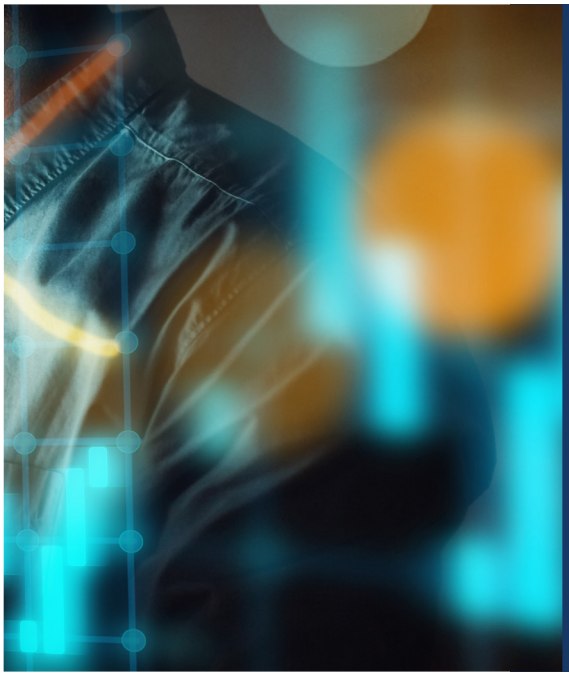
Operationalizing and Measuring Equity in Multisector Collaboratives



JSI Research and Training Institute

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In our first round of Georgia Health Policy Center (GHPC) research (October 2019–June 2020), JSI Research & Training Institute explored how multisector collaboratives (MSCs) were developing the core components of alignment. One of our findings was that many MSCs were unsure how to operationalize and evaluate equity, despite identifying it as central to their work.[1] For this round of GHPC research, we sought to obtain a clearer understanding of how MSCs are approaching equity measurement. Here, we describe this work, which is framed around two questions:

- How is equity informing MSCs' selection of interventions and use of data?
- What measures are MSCs using to monitor and document their progress toward equity?

Methods

To explore these questions, we used a mixed-methods approach. Our team reviewed 44 articles from the practice literature and selected 17 for in-depth review (see Appendix A), examined 11 tools focused on equity implementation and evaluation (see Appendix C), and conducted 24 key informant interviews (see Appendix B). Before collecting data, we did not establish a specific definition for "equity" or assess and eliminate sources based on the implied or explicit interpretations associated with the term. This was because the definitions and meanings of "equity" were integral to our research process. Our research team used two extraction matrices to code information from the documents and interviews. The coded information was then reviewed and analyzed to identify emergent themes and supportive evidence and perspectives.

Findings

Interest in equity work has increased substantially in the last few years, particularly following nationwide activism in support of Black Lives Matter and the inequities laid bare by the COVID-19 pandemic. Leaders we spoke with cautioned about the downsides of this widespread interest, noting that equity work becomes "watered down" when groups are not adequately engaged. To combat this, our informants identified six pillars that MSCs must address to operationalize equity and measure progress. By attending to the following six pillars, MSCs can mitigate harm, foster accountability, and build trust.

Pillar 1: Establish Shared Definitions and Meaning

> **It was easier building the capacity to do health equity work a decade ago than it is now, because now everybody's saying 'health equity,' but everybody does not mean health equity. It is so frustrating trying to tease out, 'Really, do you really want to deconstruct oppression and racial injustice?' They're saying health equity synonymously with disparities or diversity. —National thought leader**

To authentically engage in equity work, informants said MSCs must explore what equity means to different groups and individuals at the table. They discussed this in terms of definitions of equity as well as historical and present-day systems that maintain inequities. They did not endorse any specific definition of equity but emphasized the importance of resonance in local context, root-cause analysis that identifies historic and structural factors, and interrelationship between the concepts of health equity and racial equity. Technical assistance providers said that values exercises can facilitate these conversations: When MSC partners articulate why they value equity in relation to their sectors and work, they can identify common motivations and use these as a foundation.

Informants cited two additional strategies for developing shared definitions and meaning regarding equity:

- Use existing equity frameworks (see Appendix C)
- Review disparities data for the focal geography and identify root causes

In some cases, exploring data and root causes involves acknowledging harmful historic practices and policies implemented or supported by the MSC participants. Informants described this exploration as essential for trust building — and said it required skilled facilitation.

Views varied widely on how to treat equity work, ranging from equity work as a "train leaving the station" — that is, moving forward only with those who are ready to engage and hoping that others catch up later — to a view that organizations should spend additional time and resources "bridging" to bring people along and reach shared understanding before equity work moves forward.[2]

Pillar 2: Analyze and Redistribute Power

> **The majority of multisector collaboratives have not conducted explicit power analysis. And for that reason, I think they are more likely to end up perpetuating and reinforcing inequitable power structures, even when they're trying to address the sequelae of them, such as health inequities or problems with access to food or housing. They're talking about the different manifestations of unequal power dynamics, sometimes without acknowledging power in itself. —National thought leader**

Informants mentioned conducting a power analysis as a key tool for operationalizing equity. MSCs can implement a power analysis as they work to establish shared definitions and meaning, and to articulate the contexts in which they operate. During internal power analyses, MSC partner institutions should acknowledge roles they may have played in perpetuating inequities and explore steps they are taking or could take to mitigate harm done. Leaders suggested that MSCs use quantitative data related to structural racism (e.g., the location of redlined neighborhoods) to understand power at the community level.

Informants reflected that power analyses should be accompanied by power redistribution. Throughout this process, data and measurement can be used to identify, analyze, and ultimately break down power imbalances. MSCs should encourage institutions that have typically held decision-making authority to cede power to individuals and entities often excluded from these processes. Further, leaders cautioned against partners coming to the table with preconceived notions about which issues may matter most to residents. Informants noted that sharing responsibility can be a balancing act for backbone organizations.

Distributed leadership and dynamic governance were mentioned as ways to achieve shared power across backbone organizations and partners. For one MSC, sharing power meant being flexible with the makeup of its preliminary governing body. When community leaders were engaged in determining who would represent them on this governing body, they caucused and decided that representatives from eight distinct communities would need a seat at the table.

Pillar 3: Make a Public Commitment

> **We encourage entities to communicate externally as soon as possible. They often want to let the perfect be the enemy of the good. [But] we've learned it is important for them to commit publicly early because it creates an expectation in a way that makes it harder for them to take their foot off the gas. It creates accountability. —National thought leader**

Once an MSC has established an equity focus internally, some informants emphasized that it is important to make that commitment public to move the needle on equity. MSC leaders may hesitate to publicly share their equity focus for several reasons, including fear of a misstep, feeling like they do not have the language exactly right, or because their analysis and focus is evolving. Additionally, publicly committing to an equity focus may require institutions to acknowledge their role in maintaining or perpetuating inequitable systems.

MSCs must navigate intentionally and thoughtfully through uncertainty and ambiguity when developing an equity focus and a measurement strategy. One approach we heard was for the MSC to be transparent about the iterative process of setting and revisiting equity benchmarks or metrics and to humbly communicate lessons learned. The benefits of a public commitment include building social and political capital with potential partners, creating positive peer pressure for other entities, and fostering accountability.

Pillar 4: Engage the Community in Developing the Measurement Strategy

> **I am very frank letting folks know: 'It's not about your agenda.' … The fact is you're going home from this neighborhood tonight, more than likely to sleep in a very peaceful and comfortable environment; you are not the expert here. Because these are the individuals that are going back to possibly substandard housing conditions, or they may be going back to a neighborhood where they are living next door to a landfill. Let's listen to them more often than us coming in with our own agenda. Let's listen to what they want, what they need, what they see as their health priority for that community. —Site leader**

Informants view the inclusion of local leadership in the development of an MSC's measurement strategy as a prerequisite for engaging in equity work. Local leaders have insight into which measures will matter to residents, how to collect data, and how to effectively deliver interventions. Several strategies for engaging the community were mentioned, including conducting surveys, resident focus groups, and listening sessions; hiring a community liaison; and developing a community advisory committee that is part of the MSC board.

While MSCs differ in their exact structure — and thus in how they include community voices — informants agree that community leaders should have "seats at the table" and be a part of the MSC's governing body. Some informants spoke of the harm that results from tokenizing collaborators when groups fail to examine and alter existing power structures. One informant characterized this as follows:

> **Too often, people from underrepresented, underresourced communities are not fully empowered participants in multisector collaboratives. It's most often women of color who are carrying a disproportionate and inequitable burden to be the voice in the room, and they still don't have power in that space. —Site leader**

To avoid this, MSCs should take stock of who is invited to the table, the circumstances of their participation, and what influence they hold. Doing so can lead to trust building and more successful interventions. For example, one MSC had a predetermined impact measure in mind when it initially approached community partners but quickly realized that the target measure was not a priority for residents. After gaining feedback from the residents, the MSC pivoted to a different measure that aligned with the community input. Selecting such measures then informs the selection of interventions.

Pillar 5: Define the Throughline

> **We want to be able to say that the work that we're doing is having an impact. Making the connection between what you're measuring in your own work and how that maps onto the population level is really important. —Site leader**

MSC work is often described as ill-suited for population-level evaluation because of three factors: the implementation of simultaneous strategies, the existence of external social factors influencing health, and the amount of time it takes to move the needle on deep-rooted issues. Even so, informants indicated that it is important for MSCs to identify and attend to the "throughline" in their work, connecting and mapping out their activities (e.g., via a logic model) so that process improvements are clear and long-term, and population-level equity impacts are identified and prioritized.

With adequate funding, informants suggested that MSCs could lead efforts in their communities to use equity-informed data approaches. For example, MSCs could push for disaggregating quantitative data by race and ethnicity in specific place-based communities (e.g., life expectancy in a census tract, food security in a county, absenteeism in a school district) so that equity can be monitored over time. Although it is resource-intensive, collecting self-reported data was cited as a strategy for encouraging community participation and providing a bridge between initial activity and monitoring long-term impact. Measures such as self-reported well-being and Canrtill Ladder can be effected in the short to medium term, and research shows that they have a powerful predictive connection to long-term health and equity outcomes.[3]

Pillar 6: Tell Stories With the Data

> **In some ways, [the work] is immeasurable. It could just be an anecdotal story. For example, this past spring one of [our partners] donated land to [another partner] in order to build a community center. And that partnership, that's the first time that has ever happened that I know of, where [that kind of partner] has donated land for somebody else to build services on.**
> **—Local initiative leader**

Qualitative data and the use of storytelling were mentioned as powerful tools for showing progress on equity, as they can illustrate the "why" and "how" in addition to the "what." In particular, informants said, qualitative data is instrumental in conveying the nuances of trust, partnership, and ownership. For example, one informant described enhancing an annual partnership survey by collecting qualitative responses to better understand the impact of trust and partnership on

MSC activities. Qualitative responses were particularly useful for grasping participants' sense of inclusion and responsibility, commitment, and alignment among partners.

Informants said that whenever possible, MSCs should use qualitative data when reporting to funders (e.g., when sharing results from a strategic planning process or updating program implementation). However, they also cautioned that using qualitative data can create tension, especially with funders who prefer quantitative data or with partners who are focused on improving population-level metrics. Informants suggested that quantitative data should support qualitative data that more holistically illustrates equity processes and interventions being pursued.

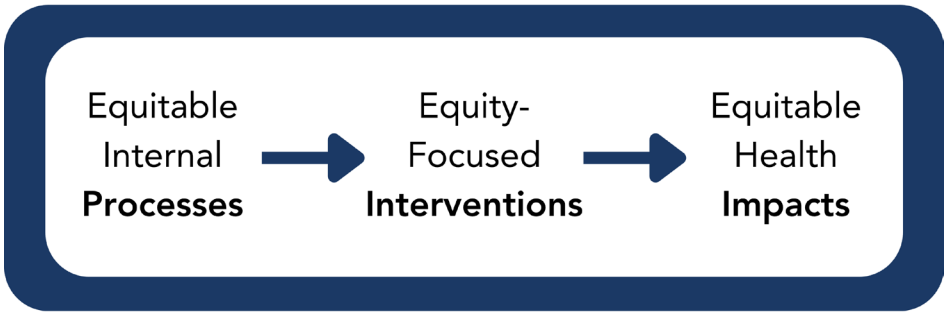
Discussion

For MSCs, equity measurement is an evolving and challenging practice area. If MSCs connect their interventions to health outcomes and the social factors that underpin them, they will be able to tell more complete and compelling stories about the work they do and its implications for equity. Still, it is also apparent from site-level and national MSC leaders that equity in process is important in and of itself and should not be viewed as only a means to reach equity in impacts.

Process Is the Engine

Practitioners and researchers voiced similar understandings of how equity can manifest and function in the MSC context; we have distilled these understandings into a simple conceptual model (see Figure 1). The model, which can be mapped across time, suggests that integrating equity into internal processes drives measurable change at the intervention and impact levels.

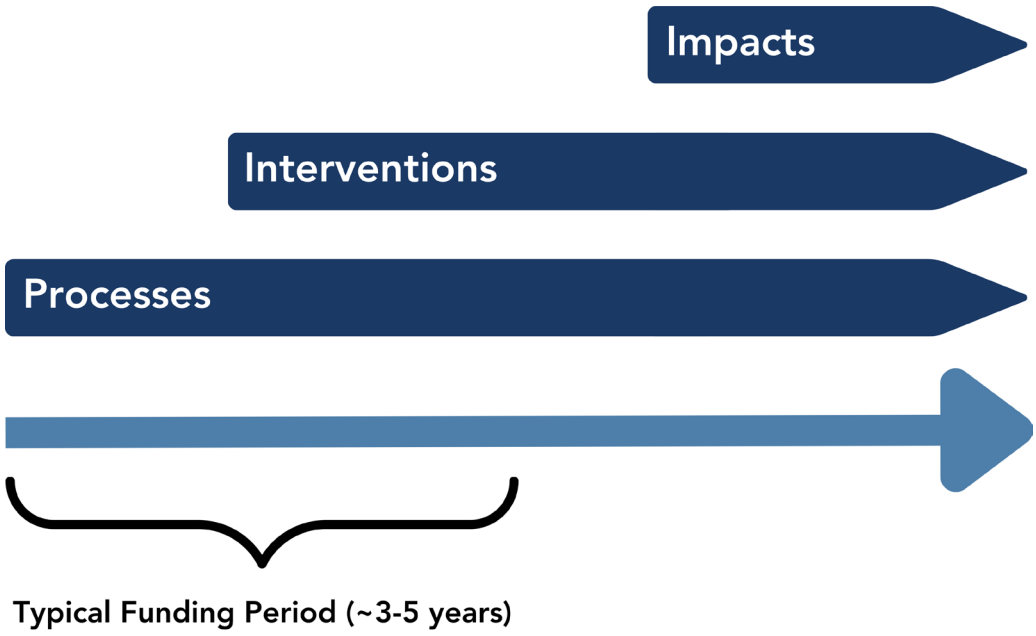
Figure 1. Equity in the MSC Context



As Figure 2 shows, for most MSCs, equity appears — and is measurable — in processes during the first three to five years. This aligns with what we found in the field. Almost all site leaders reported that, if they were measuring equity at all, they were focused on process measures related to internal operations. Only two of our informants — one affiliated with an MSC that was more than 10 years old and the other with a statewide initiative with significant financial resources — reported evaluating equity with regard to interventions, and none of our informants had assessed equity impacts at a population level.

Spending time developing and monitoring equity in internal processes is not only appropriate, but necessary. Relationships, trust, and level-setting — while well understood to be challenging and time-consuming endeavors — must be established before moving forward with an equity agenda. As Figure 1 shows, these process elements can be the engine that drives future movement on equity.

Figure 2. Typical Areas for Equity Implementation and Measurement Over Time



MSCs should use measurements related to readiness and partnership (e.g., strength of relationships, trust, degree of participation, and sense of ownership) to report back to funders about internal equity processes; such measurements can also serve as a method of accountability. Notably, these elemental process measures can be observed and reported for the duration of an MSC's existence, regardless of its maturity.

In practice, equity's sequential nature means that MSCs need to develop sequenced measurement strategies and use process and outcome evaluation frameworks to measure and report their progress. Also, MSCs should consider equity process measures separately from equity intervention measures.

Funders Turn the Ignition

If internal MSC processes are the engine that drives equity, funders may hold the key. Operationalizing equity is resource-intensive, time-consuming, and requires stable funding streams. Unsurprisingly, funders' interest in and willingness to back equity work influences whether MSCs make it a priority in their interventions and measurement.

Mismatches between funder expectations or timelines and the reality of operationalizing equity internally can present a major challenge. As discussed above, MSCs are unlikely to mature to a point of achieving equity impacts in their communities in the first three to five years. Despite this, many funders want to see measurable success at the intervention or impact level during this period, ignoring progress in internal processes. This is an unreasonable expectation; it is also potentially harmful if it leads local initiatives to begin equity work that they are not able to carry through. When calling for a focus on equity, funders must first support the foundational internal work.

Conclusion

This research demonstrates that equity measurement for MSCs is an evolving space, with the bulk of current equity measurement and activity focused on process. Two key pillars of that process are (1) developing a shared understanding of equity and (2) analyzing and redistributing power. Operationalizing equity into internal practices is a time-consuming, resource-intensive process, and if it is approached without careful intention, can cause harm. MSCs and funders must embrace time and resource realities to accomplish the work and support systems change.

Our informants identified six core pillars that MSCs can focus on to realize their equity goals. They also emphasized that equity progress can be measured through both qualitative and quantitative data. As MSCs mature, additional research should continue to shed light on equity measurement in all aspects of MSC activity, including intervention and population-level outcomes.

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Appendix A: Articles From the Practice Literature

The following are articles we reviewed for our study. Articles listed in bold were included in the full review.

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Appendix B: Interviewees

Name	Organizational Affiliation	National or Local Leader
Ana Novais	Rhode Island State Health Department	Local initiative leader
Ben Miladin	United Way of Greater Cleveland	Local initiative leader
Chris Parker	Georgia Health Policy Center	National thought leader
Dawn Wiest	Camden Coalition	Local initiative leader
Iliana Soto-Welty	Multi-Ethnic Collaborative of Community Agencies	Local initiative leader
Jen Lewis-Walden	Shift Health	National thought leader
Josie Williams	Collaborative Cottage Grove	Local initiative leader
Jubin Cheruvelil	Michigan Public Health Institute	National thought leader
Julia Caplan	Health in All Policies California	National thought leader
Karen Linkins	Desert Vista Consulting	National thought leader
Kathleen Noonan	Camden Coalition	Local initiative leader
Kim Glassman	Equal Measure	National thought leader
Kirin Kumar	HiAP California	National thought leader
Lauren Zuchman	Be Well PBC	Local initiative leader
Liz Baxter	North Sound ACH	Local initiative leader
Megan Albertson	Jackson Health Network	Local initiative leader
Natalie Burke	Common Health Action	National thought leader
Raintry Salk	Race Forward	National thought leader
Renee Canady	Michigan Public Health Institute	National thought leader
Rishi Manchanda	HealthBegins	National thought leader
Sadena Thevarajah	Health Begins	National thought leader

Name	Organizational Affiliation	National or Local Leader
Shayla Spilker	Engage R&D	National thought leader
Siobhan Constanzo	Equal Measure	National thought leader
Stephanie Bultema	Population Health Innovation Lab	National thought leader

Appendix C: Tools

As Table C1 shows, informants reported using a variety of frameworks, measures, and approaches to help them operationalize and evaluate equity. Tool appropriateness is context-dependent, with some tools being best suited to certain geographic scales and/or initiative scopes.

Tools to Operationalize and Evaluate Equity

Tool Name	Purpose	Application Phase
ABle Change Model	Operationalization and evaluation	Process, intervention, and impact
GARE Framework	Operationalization	Process
Health Begins Upstream Communications Toolkit	Operationalization	Process
HealthBegins Upstream Strategy Compass	Evaluation	Intervention
Results Based Accountability Framework	Evaluation	Intervention, impact
Rhode Island Health Equity Measures	Evaluation	Intervention, impact
Rippel Foundation's ReThink Health framework	Operationalization	Process
RWJF's Framework for Aligning Sectors	Operationalization	Process
RWJF's Aligning Systems for Health Theory of Change	Operationalization	Process
Targeted Universalism	Operationalization	Process
Well-being In the Nation (WIN) Measures	Operationalization and evaluation	Process, intervention, and impact

Understanding and Measuring Financial Alignment in Cross-Sector Initiatives for Integrated Care and Services

Kent State

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Cross-sector collaborations, which can yield positive health outcomes for underserved populations,[1,2,3,4,5,6] are multiplying across the United States.[7,8,9] Although aligning the equity-focused work of social service, public health, and health care sectors entails many challenges, one of the most significant is aligning finances.[10,11] Here, we examine four research questions (RQs) related to financial alignment:

- **RQ1.** Do the coordinators of cross-sector networks perceive financial alignment as a challenge compared to other aspects of their efforts to align services for underserved clients?
- **RQ2.** What barriers inhibit financial alignment for cross-sector networks providing services for underserved clients?
- **RQ3.** What milestones describe financial alignment progress for networks providing services for underserved clients?
- **RQ4.** How can progress in financial alignment be measured?

We address these questions using data from professionals in cross-sector networks that serve underserved populations. The analysis focuses on their perceptions of their networks' progress in aligning funding both for *sustainability* and for financial *incentivization* and *accountability* arrangements designed to help ensure their effectiveness. We also discuss financial alignment barriers and milestones, offer a framework for measuring progress in sustaining finances, and identify measurement issues for networks pursuing incentivization/accountability across their partner organizations.

Methods

After consulting with the Kent State University Institutional Review Board, we conducted our research in several steps. We first pilot-tested the survey with coordinators of two networks (one each in Texas and Pennsylvania); we then administered an online survey to various U.S. cross-sector networks that support traditionally underserved populations. Next, we conducted semistructured interviews with key informants who deliver and finance cross-sector services for underserved populations. Finally, we tabulated and analyzed the data we collected.

To identify potential survey participants, we turned to two sources: (1) the Care Coordination Learning Network, a learning forum sponsored by the Pathways Community HUB Institute® (PCHI) and the Georgia Health Policy Center (GHPC), and (2) a list of cross-sector networks provided by GHPC. We then invited 46 network representatives to participate in the survey and received 21 responses (a 46% response rate).

Next, we interviewed 14 professionals who deliver and finance cross-sector services for underserved populations. Among these interviewees were members of two networks that we surveyed (one in California, the other in Wisconsin). We selected these two networks for several reasons, including that they reported relatively high levels of perceived financial alignment, diversified revenue sources, and funding sources that — in contrast to grant funding — reimburse them for services to specific clients. Members of the two networks also offered thoughtful survey remarks on financial alignment barriers and progress. From these two networks, we interviewed a total of two coordinators, four social services partners, three funders, and a health care system that was both a partner and funder. In addition to representatives of these two networks, we interviewed the coordinator of a rural network in Minnesota and three funders (none of the funders participated in the survey). The additional funders represented two health systems and one Medicaid managed care organization (MCO). We used scripts to guide the 14 interviews, which were conducted by two project team members who combined their notes for analysis. We also sent the combined notes to the interviewees for their review and comment.

To address our RQs, we summarized survey responses and examined interview data for themes and insights. We assessed whether the survey respondents perceived financial alignment as a challenge compared to the other core alignment areas (CAAs) identified by the Robert Wood Johnson Foundation (RWJF) — that is, the areas of purpose, data and measurement, and governance. We compiled data on barriers to financial alignment as conceived by RWJF; the barriers include elements relating to both financial sustainability and incentivization/accountability.[12] We also analyzed reported information on milestones for financial alignment progress. Multiple participants referenced PCHI requirements for Pathways Community HUB (PCH) certification, so we also reviewed the PCHI prerequisites and standards necessary for this kind of certification. PCHs are outcome-focused, pay-for-performance networks of community-based organizations that hire and train community health workers (CHWs) to reach out to those in need; identify their risk factors;

and connect them to medical, social, and behavioral health services and ensure their risks are mitigated.

Findings

We had a total of 21 survey respondents from 16 states; many respondents reported initiating the planning for their cross-sector work relatively recently — a finding consistent with previous work.[13] Of the 18 who responded to the question on when they initiated cross-sector planning, 56% (10 of 18) reported initiating planning since 2016, and three more (17%) reported doing so since 2011.

Survey respondents reported that their networks engaged with multiple organizations, target audiences, and funding sources. The most commonly identified network partners were community-based organizations, social services agencies, health care organizations, federally qualified health centers, and health departments, followed by governments, local foundations, health plans, and housing agencies. Common target populations included adults with chronic illness, pregnant women, and adults with substance use disorders. On funding, more than half of respondents (12 of 21) reported receiving state grants in 2020, 10 of which were for less than $250,000. Other funding sources included federal and foundation grants, local governments, donations, health care systems, and MCO reimbursement funding.

Respondents used different approaches to guide network organization. Of the 21 networks, five were PCHI-certified, indicating that their PCHs had demonstrated fidelity to the PCHI Model, seven were interested in the PCHI Model but were not certified, and the remaining nine used other organizational approaches.

Perceptions of Financial Alignment

RQ1. Do the coordinators of cross-sector networks perceive financial alignment as a challenge compared to other aspects of their efforts to provide services for underserved clients?

Table 1 compares survey responses across RWJF's four CAAs, and the responses suggest challenges with financial alignment (a finding consistent with past work[10,11]). Across all

respondents, finances and data and measurement are reported as highly or very highly aligned relatively *infrequently* (all less than 45%), suggesting that these alignment areas are the most challenging CAAs for the networks responding to the survey. Furthermore, while the challenges of financial sustainability and data and measurement seem to apply across organizational alignment approaches, there are notable differences between certified PCHs and other responding networks. Relatively high proportions of coordinators from certified PCHs reported high or very high levels of financial alignment for incentivization/accountability (100%) and sustainability (40%), a clear contrast to the entire sample's figures for incentivization/accountability (43%) and sustainability (19%). While the figures in Table 1 are not sufficient to conclude that higher levels of perceived financial alignment *result from* PCHI certification, they do suggest that there may be value associated with PCHI certification.

Table 1. Perceptions of Alignment Around Purpose, Data and Measurement, Finances, and Governance

Core Alignment Area (CAA)	CAA Measure	No. (%) of Cross-Sector Network Coordinators Reporting High or Very High Alignment Levels (by Alignment Approach)			
		PCHI-certified	Network interested in PCHI Model	Other cross-sector networks	Total (across respondents)
Purpose	Partners share vision	4/5 (80%)	5/7 (71%)	8/9 (89%)	17/21 (81%)
	Partners operate according to shared priority outcomes	4/5 (80%)	3/7 (43%)	5/9 (56%)	12/21 (57%)
Data and measurement	Partners use shared data and measurement system	2/5 (40%)	2/7 (29%)	2/9 (22%)	6/21 (29%)
Finances	Network produces sustainable financing	2/5 (40%)	1/7 (14%)	1/9 (11%)	4/21 (19%)
	Financial system has incentives and accountability for results	5/5 (100%)	2/7 (29%)	2/9 (22%)	9/21 (43%)
Governance	Governance engages those involved in cross-sector efforts to participate	5/5 (100%)	5/7 (71%)	2/9 (22%)	12/21 (57%)
	Governance guides strong decision-making structures and processes	4/5 (80%)	3/7 (43%)	3/9 (33%)	10/21 (48%)

Four Barriers to Financial Alignment

RQ2. What barriers inhibit financial alignment for cross-sector networks providing services for underserved clients?

Funding

Barrier 1: Limitations on available funding and competition for that funding

This barrier was commonly identified by both network coordinators and collaborative partners. A respondent from Oregon, for example, noted that competition for grants was often a "zero-sum game," where that competition for financial support limited both the funds available and the collaboration and trust across organizations that is needed for cross-sector collaboration. Respondents also indicated that the needs for funds are great and funding is limited, while also recommending both diversified funding sources and reimbursement-based funding from health care payers, as such funding is viewed as more stable than grants.

Service Delivery and Support Issues

Barrier 2: The structure of state health services delivery and insufficient support for integrated services

Coordinators of the California and Wisconsin initiatives emphasized the importance of state policies and indicated that their states were still learning how best to support cross-sector services for underserved populations. In California, the coordinator and the initiative partners indicated that needed changes should include ensuring that social determinants of health care management are a benefit in the state's Medicaid program redesign. Wisconsin respondents suggested a need to develop more effective state-level systems for delivering funds to cross-sector networks. State funding support concerns were also evident in the survey responses. Coordinators from Connecticut and Minnesota said that their states did not yet have funding systems with reimbursement contracts for their cross-sector services for specific clients. In Ohio and Michigan, which have outcome-based reimbursement contracts for services to Medicaid recipients, respondents reported that funds from

these sources did not cover the full costs of integrated service delivery — particularly, overhead costs. One Ohio respondent also suggested that state grant funding sources were insufficient and reimbursement-based contracts with MCOs were "too narrow regarding who and how they pay for outcomes."

Stakeholder Divisions

Barrier 3: Cultural, attitudinal, and practice divides across service sectors and funders

These divides exist across sectors and funders, and multiple respondents addressed divides across social service and health care organizations. The California coordinator indicated that health systems and MCOs need to develop understanding and respect for social services staff and their professional abilities to address important client risks. They also noted that health systems were often reluctant to refer enough clients to fully support cross-sector services. The Wisconsin coordinator said that some health care systems bring CHWs into their practices to assist with clinical services, when CHWs should be used in the community to address social determinants of health and expand client volumes. In contrast, an MCO payer expressed concerns about the capacities and sophistication of social service providers, who may have little experience with health care payers. This payer noted that some cross-sector networks and social service providers lack familiarity with claim-based funding and the extensive verification and documentation it requires.

Uncertain Results

Barrier 4: Uncertainty on the extent to which integrated services improve health outcomes and reduce costs

Although social determinants of health are acknowledged to affect health outcomes, evidence on the positive impacts of addressing them can and should be improved.[14] Service providers and payers both recognized a need to build a stronger evidence base for returns on investment to prove integrated services' value and enable more realistic — and perhaps, more generous — pricing in contracts for cross-sector services. Improved evidence on returns on investment could potentially

enhance both sustainability and incentivization/accountability by building a case for more generous payments and providing resources to further incentivize and hold participants accountable for results.

Useful Milestones

RQ3. What milestones describe financial alignment progress for initiatives providing services for underserved clients?

Our respondents generally shared similar views on milestones that characterize their networks' financial alignment progress on sustainability. They emphasized the importance of developing shared purpose among participating organizations to focus their efforts and guide fundraising. They also emphasized the need to demonstrate results, diversify funding sources, increase client volumes, and obtain reimbursement funding to support services for specific clients — all of which are likely to foster sustainability. It is worth noting in this context that reimbursement funding can come in differing forms, including fees for services, per-person case rates, and payments for outcomes (a la the PCHI Model). Also, most respondents offered more observations on sustainability than on incentivization/accountability, and they often noted that incentivization/accountability can be only as strong as the funding flows supporting it.

Our respondents offered differing perspectives on milestones for measuring progress on incentivization/accountability. Some of these differences align with the organizational approaches that networks used to deliver their cross-sector services. Coordinators of the five certified PCHs were generally confident in their financial incentivization/accountability arrangements. PCHI's certification prerequisites and standards require PCHs to have at least 50% of their payments come from at least two contracts that pay for confirmed outcomes.[15,16] Coordinators of networks interested in PCHI certification often indicated that certification was a key milestone for progress in this area, yet they also identified challenges in developing funding arrangements consistent with PCHI requirements. Responses from networks using approaches unrelated to the PCHI Model were more varied and reflected the broad range of forms that incentivization/accountability efforts can take. The incentivization/accountability milestones that these networks reported ranged from not yet

having focused extensively on this issue, to asserting compliance with performance requirements in their grants, to bonus payments for high-performing employees. Overall, our survey results revealed little consensus across networks on financial incentivization/accountability milestones.

In spite of the differing perspectives on incentivization/accountability expressed by the network coordinators surveyed, both of the California and Wisconsin coordinators interviewed noted that their networks were successful in obtaining funds and that they shared that financial success with their network partners — potentially a key milestone for incentivizing partners and enabling accountability. Their collaborating partners generally concurred but often indicated that current network funding flows were insufficient to cover the full costs of the cross-sector services they provide. They reported that the financial incentives were often modest and might be less impactful than their professional staff members' drive to provide needed support to those they serve. Thus, while the partners acknowledged benefits associated with network funding, they also suggested that network benefits related as much or more to building new competencies by working with health care payers and to more fully supporting their clients than to the network's financial incentives.

Measuring Financial Alignment

RQ4. How can we measure progress in financial alignment?

Our findings revealed two different approaches to answering RQ4 — one focused on a framework for understanding and measuring progress for sustainability, and another focused on identifying issues to address in measuring progress for incentivization/accountability.

Table 2 summarizes a proposed five-stage framework for understanding and measuring progress on financial alignment for sustainability. The framework's first and second stages focus on initiating and building support for financial alignment efforts, while the third and fourth stages center on establishing a financial foundation for the network and growing and expanding it over time. In the fifth stage, cross-sector networks achieve ongoing long-term sustainable financing. While Stage 5 appears to represent a goal rather than a description for the networks we surveyed, we propose it here as a defensible end-point measure for the accomplishment of sustainable

finances. Table 2 thus describes five developmental stages, and individual cross-sector networks can use it to assess their progress at each stage. Data supporting these measures should be available from network personnel, governing documents, funding contracts, and reports on financial support received.

Table 2. The Progress Continuum in Cross-sector Financial Alignment for Sustainability

Stage/Name	Description	Measure of Accomplishment
1. Initiated	Cross-sector stakeholders and organizations align purposes, demonstrate success, and obtain initial funding	Initial funding in place, with documented cross-sector community purpose
2. Building	Funding support from multiple funders	Multiple funding sources committed to supporting the cross-sector initiative
3. Established	Reimbursement funding tied to services provided to at-risk clients	At least one service-based reimbursement funding agreement tied to existing client services
4. Growth and Expansion	Reimbursement funding from at least one source that is sufficient to cover client service costs	Service-based reimbursement agreements that tie dollars to client services at volume or at fee levels sufficient to cover client service costs
5. Sustainable	Reimbursement funding sufficient to support both client services and fixed costs/investments over time	Reimbursement funding sufficient to support both client services and fixed costs/investments over time

Variations in respondent viewpoints on key milestones for incentivization/accountability make developing a widely applicable measurement framework challenging. However, the insights from respondents, along with the PCHI certification requirements, helped us to identify four issues that network participants can consider as they develop strategies for measuring progress on incentivization/accountability. First, *incentivization/accountability progress requires that*

resources are available to support financial incentives and accountability. Cross-sector networks should thus assess the adequacy of their funding flows as they work to develop effective strategies for measuring their progress on financial incentivization/accountability.

Second, *measures of incentivization/accountability should determine whether the amounts of payments made are large enough to incentivize network partners and hold them accountable for results*. The PCHI standards suggest that at least 50% of incoming payments come from sources that directly tie payments to achieved outcomes. While the adequacy of the 50% criterion is open to discussion, it illustrates a possible measurement criterion for addressing incentivization/accountability from the perspective of the magnitude of incentive provided.

Third, *measures of incentivization/accountability progress should assess whether incentives and accountability apply across the entire cross-sector network.* Measures should address how payments to the network are distributed among organizations/individuals contributing to its work. PCHI prerequisites and standards require that certified PCHs demonstrate that payments made to partners be "related to … steps/outcomes using national Standards." The prerequisites and standards also apply this outcome-based payment structure to payments from funders to the PCH as well as to payments from the PCH to contracted cross-sector partners to reimburse for their contributions to achieving desired outcomes. At least one network we investigated also recommends that its partners pass incentive payments along to their CHW service providers.

Finally, *measures of financial alignment progress for incentivization/accountability should maximize consistency between payment structures and the network's vision and priorities*. For networks focused on underserved populations, for example, measures should focus on outcomes that matter to underserved clients, as well as on metrics tied to funder costs (for example, per-member, per-month payments, which are now common in the health care sector). This need for consistency in payment strategies is made by scholars of health reform and value-based payment systems,[17] and it is also consistent with PCHI's payment-based structures.

Discussion and Conclusions

As we noted earlier, cross-sector collaborative networks that address equity issues and provide services to underserved populations are proliferating because they can yield positive impacts on

health outcomes. The findings presented here include progress measures and insights for both practitioners and researchers with interests in cross-sector services. For practitioners, the measures of financial alignment for sustainability in Table 2 provide a roadmap for building funding flows to support their cross-sector services. In addition, the issues we identify to guide cross-sector strategies for pursuing financial incentivization/accountability suggest specific areas for their further attention in this regard.

Researchers may also benefit from our measures and insights, which provide a foundation for measuring progress on sustainable finances and developing incentivization/accountability measures. Our sustainability measures suggest that reimbursement funding is important for building long-term sustainable financing; they also provide a foundation for more systematic studies comparing cross-sector networks, their developmental paths, and their impacts. The issues we identify for measuring incentivization/accountability can help guide deeper thought on how best to incentivize and hold parties accountable for progress toward key cross-sector network goals and priorities.

Our contributions do have some limitations. First, while our sample of cross-sector initiatives is substantial, it is not derived from a well-defined universe of cross-sector initiatives across the country. It would be valuable to define the full universe of these initiatives and assess our measures against a larger set of cross-sector partnership experiences.

Second, while our findings identify connections between incentivization/accountability and sustainability, they do not yet provide a simple, easy way to measure RWJF's general concept of financial alignment. It may be beneficial to think further about ways to better integrate these two dimensions of financial alignment — or it might make sense to simply recognize that sustainability and incentivization/accountability are two distinct areas.

Third, researchers may face challenges in operationalizing our financial sustainability measures. While the measures are conceptually clear, arguably valid, and measurable using available data sources, our experiences show that professionals supporting cross-sector alignment initiatives may have different perspectives that could complicate efforts to achieve reliable measurement. In this sense, it may be appropriate to revisit our proposed measures and push toward greater specificity over time.

Despite these limitations, there is a need to better understand financial alignment for cross-sector initiatives. We need to identify barriers to achieving this kind of alignment and develop ways to measure its progress. By doing so, we can guide efforts to enhance cross-sector services and support research that can shine further light on the benefits and financial challenges facing cross-sector networks that work toward health equity. It is our hope and expectation that this work to identify barriers, measures, and measurement issues contributes positively to these efforts.

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Developing Measures for Aligning in Multisector Collaboratives

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Stakeholders in multisector collaboratives (MSCs) need evidence of progress to support their work, but such evidence is challenging to come by. Measuring cross-sector work is hard, not least because it is challenging to figure out what to measure and how to measure it, how to reliably collect and analyze evidence, and how to share findings in a timely and useful manner. Our research aims to identify and validate indicators for aligning that MSCs can use to measure, compare, and assess the relative importance of concepts from the Framework for Aligning Sectors.[1]

Our first step in developing measures for aligning was to venture beyond the traditional knowledge bases of public health and health care. Our Population Health Innovation Lab (PHIL) research team explored various social science disciplines, including their past research, theories, and frameworks. The work we describe here drew on four key bodies of knowledge:

- The Integrative Framework for Collaborative Governance to guide measurement[2,3,4]
- Theories of collective action and cross-sector collaboration to guide our understanding of how large-scale collaboration works in practice[5,6,7,8,9]
- Network theories and methods to guide assessment and interpretation of the structural elements of aligning[10,11,12,13,14]
- The Framework for Assessing Accountable Communities for Health (ACHs) to guide our understanding of ACHs, which is the type of MSC that our study targets[15]

Methods

Our approach to measurement validation builds on a mixed-methods research design that uses a realist evaluation lens to learn how people perceive relationships among aligning processes and outcomes.[16] We used data collected through our existing research with ACHs — that is, health-focused MSCs that align communities around a shared vision for health.[17] We also gathered new evidence to assess reliability, validity, feasibility, and utility of aligning measures.

Data Sources and Collection Methods

We used several sources and methods of investigation to collect and analyze evidence for this project. Data available from existing PHIL research included survey responses from 598 participants from 20 ACHs, 65 interviews, four focus groups, nearly 700 documents, and secondary data. We collected additional data to inform measurement validation by conducting a validation survey, two additional focus groups, and 20 additional interviews with representatives of nine ACHs.

Analytic Approach and Methods

Our project used a mixed-methods approach to address reliability and validity issues.[18,19] To explore the relationships among aligning concepts, our analyses used descriptive and inferential techniques. We conducted latent variable analyses — including exploratory factor analysis (EFA), confirmatory factor analysis (CFA), and structural equation modeling (SEM) — in R (a computer language and environment for statistical computing) using the lavaan package.[20,21] We conducted constant comparison analysis in Dedoose, and we assessed intercoder reliability in NVivo.[22,23,24,25]

Validation Process

For their findings to be useful in practice, measures must be both reliable and valid. A *reliable* measure consistently yields the same result each time it is used, while a *valid* measure accurately measures what the researcher intends for it to measure. We assessed four types of validity: (1) convergent validity, which assesses whether the measures for a construct match up as we expected, (2) face validity, which assesses whether the measures are understandable and resonate with end users, (3) content validity, which assesses whether a concept's full spectrum is being measured, and (4) construct validity, which assesses whether the intended concept is being measured.[18,19] We also focused on the feasibility and utility of measures and measurement approaches.

Research Findings

Our research findings provide ample evidence of the validity of aligning concepts and measures. In our first step, we conducted a series of quantitative tests using survey and population data to assess convergent validity. We used EFA, CFA, and SEM to test whether people's perceptions of measures and concepts matched up as expected. These initial quantitative tests showed that most aligning concepts can be measured with a high degree of reliability and validity. Appendix A summarizes the results of the measurement model.

Local Context

The Framework for Aligning Sectors reminds us to pay attention to *local context* since an aligning effort's location and conditions impact aligning progress and outcomes. Five latent variables emerged from our data on local context: (1) local characteristics (partnership size, attributes of the population served, etc.), (2) capacity (funding levels, the size of the aligning effort's dedicated staff, etc.), (3) antiracism, including whether aligning participants believe systemic racism exists, (4) length of individual and organizational participation, and (5) levels of individual and organizational engagement.

Qualitative findings further validate local context concepts and measures, most importantly that local context shapes everything else in an aligning effort. We also learned ways to improve the validity of local context measures. For example, while respondents viewed measuring and accounting for participation and engagement across ACH activities as essential, they felt that *depth* of engagement is an important idea that needs more measurement options. The construct validity of antiracism measures could also be improved; some participants felt that others might report a perceived "right" answer instead of their true feelings.

Core Components

In the Framework for Aligning Sectors, the core components — purpose, governance, data, and finance — are the gears that enable an aligning initiative to operate effectively. Our findings validate survey measures for three of the four core components. Survey data showed that shared

purpose can be measured by asking about a respondent's understanding of and commitment to the vision for aligning. Shared financing can be measured by asking about the value of aligning and whether there are financial resources to support the effort. Shared data can be measured by asking about tracking progress toward outcomes and whether data are regularly shared with aligning participants. These three factors matched what we expected based on the framework's guidance.

The process for validating measures for core components yielded a surprising finding — we identified a possible fifth component: *collective action*. We first identified this component through EFA and CFA, and further validated it through SEM, interviews, and existing theory.[5,6,7,8,9] The collective action component includes engaging diverse communities and multiple sectors in aligning efforts, effective communication with the broader community, participants operating in the shared interest of the aligning effort, and so on.

Our qualitative evidence also supports the validity of core component concepts and measures. Measures of collective action were particularly well received, with respondents reacting positively to the multiple options for measuring diverse engagement. Participants also shared ideas related to core components that are missing from the measures, which offers an opportunity to increase content validity for this concept. For example, several respondents felt that it is more important to ask *how* the ACH is doing their work than to ask whether it is being done. For example, on the collective action measure *The MSC currently ... engages ethnically & racially diverse communities in MSC activities*, one respondent said the following:

> **I think diving more into that question is really, really important. How do they do that? Have they been successful? How have these different communities responded? Are they continuing to collaborate?**

Adaptive Factors

The Framework for Aligning Sectors shows how adaptive factors weave throughout — and in turn, influence — everything that happens in an aligning initiative. The concepts of trust, community voices, and equity were validated through quantitative and qualitative analyses of observed measures. Survey data showed that trust can be measured by asking about other participants'

trustworthiness and reliability and whether respondents feel their opinion is appreciated and respected. Community voices can be measured by asking about the aligning initiative's progress in engaging residents in the work, offering support and resources to ensure community residents can participate, and making meetings accessible to everyone. Equity can be measured by asking about the extent to which the aligning initiative applies principles of equity, diversity, and inclusion throughout its work; how it effectively promotes equity; and whether health equity is an important outcome of the aligning effort. These three factors matched what we expected to see based on the framework's guidance. Validating the power dynamics concept proved more challenging, as we found a lack of conceptual clarity about how power dynamics differ from other adaptive factors.

Overall, we found that the adaptive factors measures have strong face and construct validity but that there is room to improve the content validity of some concepts. For example, respondents shared that trust can be built by sharing decision-making power with community members impacted by aligning work, respecting community members who share their perspectives, being transparent with decisions, and following through on promises made. Representation was another key idea among respondents, who felt that true community representation at the decision-making table was critical, including participant diversity in various areas such as racial/ethnic, geographic, cultural, lived experience, and role in the ACH and the community. Showing respect for community voices by paying for time spent on aligning work was also key. Regarding equity, one participant noted additional components to measure:

> **I'd like measures that would really get at an individual sense of belonging and respect that they're receiving, and how much their input or input from communities … are clearly being used … and you can track that to the decision that was made.**

Outcomes

According to the Framework for Aligning Sectors, outcomes can be grouped into two broad categories: short-term and long-term. Short-term outcomes include things such as changes in mindsets, policies, and practices, while long-term outcomes include things such as improvements

in equity and reductions in health disparities. Because ACHs have existed for only five years or so, our analysis focused on short-term outcomes. The outcomes of effectiveness and alignment relate to changes in mindsets and practices. Effectiveness includes two key indicators:

- Indicators of perceived changes in mindsets, such as people viewing their participation in the aligning initiative as a worthwhile use of time; and
- Indicators of perceived changes in practice, such as participants working together to identify information needs and increased collaboration across sectors.

The alignment outcome also captures perceived changes in practice, such as improvements in alignment of resources and activities, and reduced duplication of efforts. Overall, respondents were satisfied with the measures for effectiveness and alignment, indicating high face, construct, and content validity.

Practical Application

If aligning measures are to be used in practice, they must be accessible, be easy to use, and collect valuable information. Three notable themes emerged in the interviews and focus groups on this topic. First, participants noted the need to attribute findings to the ACH's efforts. Second, many said that specific measures were more useful than general ones. Third, participants generally agreed on the value of qualitative data collection to assess ACH progress and said it can lead to a better understanding of the complexities of community experience and ACH impact.

Our research identified both barriers to and facilitators of measuring aligning. Primary barriers include delayed data, lack of staff capacity or expertise, and data sharing challenges. We also learned about important measurement facilitators. For example, we found that initial measurement planning should be informed by diverse and representative community voices and cross-sector partners. Further, data should be collected at a wide range of community locations and materials should be offered in multiple languages to facilitate elevation of community voices. Many people also noted the importance of storytelling to demonstrate ACH progress and said that qualitative data collection is more feasible for many ACHs, especially those without a data specialist on staff.

Discussion and Conclusions

The long-term, process-heavy work of aligning requires a different kind of measurement than is often used in the health sectors. Aligning requires measuring both the "how" and the "why" that eventually lead to the "so, what now?" MSCs can choose to measure aligning in many ways, with key considerations being their available resources, time constraints, and the purpose of the measurement. Past research has established the link between successful aligning now and positive outcomes later, which should empower MSCs to use aligning data to demonstrate their aligning efforts' value to funders and other stakeholders.[4,26,27,28]

Future Research

During our rapid-cycle research focused on developing measures for aligning, we encountered several quandaries that are worth further exploration. We learned that adaptive factors are hard to separate because the concepts of trust, equity, power dynamics, and community voices are often intertwined. We found that measuring power dynamics is particularly challenging because the concept is relational and appears across multiple units of analysis. One way to understand power's relational aspects is to use network analysis — a scientific method for understanding interconnectedness — which can yield insight into the complex web of relationships among MSC participants.[11,29,30,31] We validated the hypothesis that equity should be considered as both a process and an outcome of aligning. As an adaptive factor, equity shows up as equitable processes that demonstrate an MSC's commitment to equity, diversity, and inclusion. As an outcome, equity shows up as progress toward improving equity in communities or as decreases in health disparities. Finally, we identified four important aligning concepts — representation, collective action, effectiveness, and alignment — that should be given further consideration and measured along with existing Framework for Aligning Sectors concepts.

Next Steps for Developing Measures for Aligning

Our PHIL team's measurement validation research is a leap forward in consolidation and validation of measures for aligning, yet there is still much to do to prepare MSCs to measure their

aligning work. We would like to see additional measures validated for power dynamics, shared governance, and equity, with more specific measures developed and validated for all aligning concepts. There is also a need to identify best practices for effectively engaging communities in measurement and operational processes; this should be done in a way that builds trust and creates results in centralizing community voices in the shared data concept. Finally, there would great value in developing a comprehensive resource to guide MSC measurement work. It is our hope that the PHIL research presented here is just the start of a more robust measurement journey for MSCs.

Limitations

The multipronged, mixed-methods approach to our measurement validation study provided a strong foundation for inquiry. However, our study has limitations. One is that our validated measures cover some portions of the Framework for Aligning Sectors better than others. Limitations also exist in the ability to generalize our findings to MSCs other than ACHs, as well as to cross-sector aligning work beyond the two states included in our study (Washington and California). This research is by nature an assessment of subjective realities — that is, of how participants perceive aligning in practice. Objective measures, such as how aligning is actually occurring, are not measured. Finally, the fact that our study was conducted during a global pandemic that severely impacted local economies, individual health and well-being, and many other aspects of daily life may have been influenced our results.

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APPENDIX A: CFA MEASUREMENT MODEL

The CFA Measurement Model: Standardized Loadings for First-Order Factors

	Local Context					Adaptive Factors			Core Components				Outcomes		
Aligning Measures	Local Characteristics	Capacity	Antiracism	Participation	Engagement	Community Voices	Equity	Trust	Shared Purpose	Shared Data	Shared Financing	Collective Action	Equity	Alignment	Effectiveness
Number of partners	0.86														
Population density	0.70														
Total population	1.00														
Median annual household income	0.86														
Initial funding amount		1.27													
Staff size		0.73													
Belief that racism exists			0.97												
Racism problem in the local community			0.88												
Racism problem in the U.S.			0.96												
Attention paid to race and racial issues			0.75												
Individual length of participation				0.66											
Group length of participation				0.93											

	Local Context					Adaptive Factors			Core Components				Outcomes		
Aligning Measures	Local Characteristics	Capacity	Antiracism	Participation	Engagement	Community Voices	Equity	Trust	Shared Purpose	Shared Data	Shared Financing	Collective Action	Equity	Alignment	Effectiveness
Individual level of engagement					0.88										
Group level of engagement					0.69										
Engages diverse groups to inform work						0.76									
Involves residents in decision-making						0.74									
Makes meetings accessible						0.72									
Supports participation from marginalized groups						0.84									
Explicit focus on health equity							0.87						0.87		
Applies equity, diversity, inclusion							0.90						0.90		
Promotes equity							0.89						0.89		
Feel appreciated and respected								0.81							
Feel other participants are trustworthy								0.90							
Feel other participants are reliable								0.92							

	Local Context					Adaptive Factors			Core Components				Outcomes		
Aligning Measures	Local Characteristics	Capacity	Antiracism	Participation	Engagement	Community Voices	Equity	Trust	Shared Purpose	Shared Data	Shared Financing	Collective Action	Equity	Alignment	Effectiveness
Can describe vision									0.71						
Can describe how vision will be achieved									0.88						
Commitment to vision									0.81						
Tracks equity progress										0.85					
Regularly shares data										0.82					
Identified value proposition for sustaining work											0.82				
Individual level of engagement					0.88										
Group level of engagement					0.69										
Engages diverse groups to inform work						0.76									
Involves residents in decision-making						0.74									
Makes meetings accessible						0.72									
Supports participation from marginalized groups						0.84									

	Local Context					Adaptive Factors			Core Components				Outcomes		
Aligning Measures	Local Characteristics	Capacity	Antiracism	Participation	Engagement	Community Voices	Equity	Trust	Shared Purpose	Shared Data	Shared Financing	Collective Action	Equity	Alignment	Effectiveness
Explicit focus on health equity							0.87						0.87		
Applies equity, diversity, inclusion							0.90						0.90		
Promotes equity							0.89						0.89		
Feel appreciated and respected								0.81							
Feel other participants are trustworthy								0.90							
Feel other participants are reliable								0.92							
Can describe vision									0.71						
Can describe how vision will be achieved									0.88						
Commitment to vision									0.81						
Tracks equity progress										0.85					
Regularly shares data										0.82					
Identified value proposition for sustaining work											0.82				

	Local Context					Adaptive Factors			Core Components				Outcomes		
Aligning Measures	Local Characteristics	Capacity	Antiracism	Participation	Engagement	Community Voices	Equity	Trust	Shared Purpose	Shared Data	Shared Financing	Collective Action	Equity	Alignment	Effectiveness
Communicates value to funders/investors											0.82				
Identified financial resources to sustain work											0.78				
Effective communication with community												0.72			
Participants operate in shared interest												0.68			
Engage diverse communities in ACH activities												0.76			
Provides opportunities for public participation												0.71			
Active engagement of multiple sectors												0.74			
Helps align resources and activities														0.85	
Improves collaboration effectiveness														0.84	
Gets things done														0.81	

	Local Context					Adaptive Factors			Core Components				Outcomes		
Aligning Measures	Local Characteristics	Capacity	Antiracism	Participation	Engagement	Community Voices	Equity	Trust	Shared Purpose	Shared Data	Shared Financing	Collective Action	Equity	Alignment	Effectiveness
Reduces duplication of efforts														0.87	
Supports cross-sector collaboration														0.87	
Feel participation is worthwhile															0.78
New knowledge gained															0.76
Believe work should continue after initial funding															0.68
Collective identification of information needs															0.82
Confidence in MSC effectiveness															0.83
Convenes across sectors in a new way															0.69
Increases collaboration															0.86
Making progress on system transformation															0.70

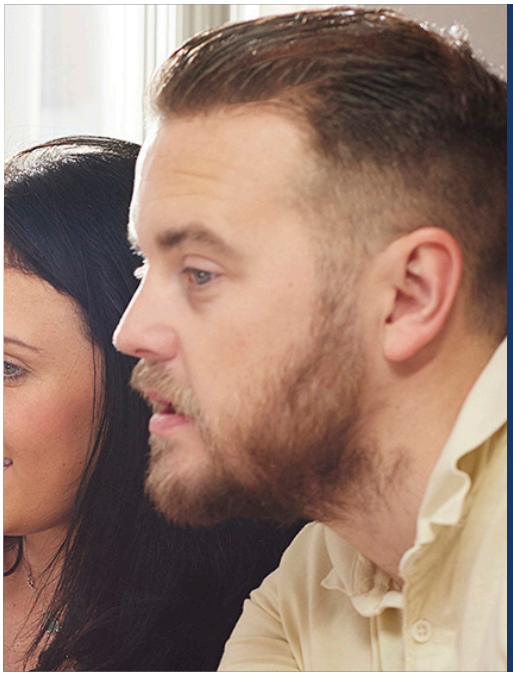
	Local Context					Adaptive Factors			Core Components				Outcomes		
Aligning Measures	Local Characteristics	Capacity	Antiracism	Participation	Engagement	Community Voices	Equity	Trust	Shared Purpose	Shared Data	Shared Financing	Collective Action	Equity	Alignment	Effectiveness
Participants understand how to contribute															0.68
Composite reliability (> .7 desired)	0.93	0.92	0.90	0.83	0.77	0.80	0.86	0.83	0.79	0.83	0.79	0.79	0.86	0.86	0.90
Average variance extracted (> .5 desired)	0.82	0.93	0.80	0.69	0.68	0.58	0.68	0.73	0.63	0.74	0.65	0.57	0.68	0.67	0.56
N = 596; all loadings shown in this table significant at $p < .001$															

Chapter Three

Adopting Aligning Frameworks

The Aligning Systems for Health initiative was born out of the recognition that more deliberative and sustainable work between the health care, public health, and social services systems was needed. The Framework for Aligning Sectors (formerly the Cross-sector Alignment Theory of Change) guided the research of seven grantees awarded $2.4 million for 24 months through the Aligning initiative. Grantees were funded to study the approaches and conditions that foster collaborative systems to meet the goals and needs of the communities they serve, in particular the components of shared purpose, governance, financing, data, power dynamics, equity, trust, and community voices. The grantees studied collaborative systems across the nation in New Jersey, Kentucky, North Carolina, South Carolina, Illinois, Wisconsin, Oklahoma, Texas, Arizona, California, Washington state, and Idaho. The awarded organizations, Public Health Institute, Rush University Medical Center, Texas Health Institute, Trenton Health Team, University of Louisville, University of South Carolina, and the University of Washington, focused on different aspects of the Framework for Aligning Sectors and contributed to the collective learning about aligning. Findings from each of the grantees can be found in this chapter.

Improving Understanding of Aligning Across Sectors by Exploring Outcomes in Accountable Communities of/for Health



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Traditional ways of addressing issues that contribute to poor health often fail to get to the root of the problem. Instead, communities typically apply single-focused programs that, while helpful, have only a Band-Aid effect. Aligning efforts across sectors is one approach to addressing the root causes of poor health outcomes.

Our study sought to improve practical and scholarly understanding of aligning across social services, public health, and health care sectors — in partnership with communities — by exploring the local context of 22 communities and aligning mechanisms that are most likely to be associated with successful and sustainable outcomes. We explore aligning in the context of U.S. community health systems — specifically, in cases with accountable communities of/for health (ACHs). These ACHs are community-driven initiatives led by backbone organizations with the goal of supporting resource alignment and stewarding systems change activities to create the conditions needed for whole-person health and wellness.[1]

Our findings contribute to an improved understanding of when and why aligning produces positive outcomes such as effective cross-sector alignment, improved health equity, and sustainability of aligning efforts. We begin here with an overview of knowledge about aligning from the existing literature, then present our research questions, our methods, and an overview of our study's findings. We close with evidence-based conclusions about how an improved understanding of aligning can lead to better outcomes.

Theory: Building on the Literature

Over the past decade, public health theories and practices have shifted and increasingly acknowledge the importance of policies, environments, and systems in preventing poor health outcomes. This has resulted in a general understanding that improving population health must involve the engagement of multiple sectors and community partners to improve the underlying causes of health outcomes. These underlying *social determinants of health* highlight how social factors — such as education, transportation, housing, race/ethnicity, and other nonmedical influences — contribute to a person's potential to live a healthy life.[2] By focusing on addressing social determinants of health, public health practitioners have ventured beyond simply stating that cross-sector alignment is a "good thing" to do, to advocating for it as the "necessary thing" to do.[3] The growing consensus that

cross-sector collaborations and partnerships "are an essential component of the strategy to improve health and well-being in the United States" comes with a new responsibility: Public health, social services, and health care practitioners must collaborate with the communities they serve and align their efforts across sectors.[4] ACHs are one example of how communities operationalize aligning across sectors by adopting an intentional model that changes how the aligning sectors do business.

Our study builds on learnings from diverse literature, including lessons from the public health, health policy, social sciences, and public affairs domains. Our review includes topics such as social determinants of health,[5,6,7] ACHs,[8,9,10] cross-sector collaboration,[11,12,13] interorganizational collaborative networks,[14,15,16] collective action,[17,18,19] collective impact,[20,21,22] and collaborative governance.[23,24,25] We offer a brief review of the literature that informed our study below. Overall, the literature shows that while the growing recognition of alignment's importance for improving population health has led to the adoption of various solutions to transform the health system, few of those solutions offer evidence-based guidance on how to effectively align in practice.[26,27,28,29,30] For this study, we focused on testing the hypothesis outlined in the Framework for Aligning Sectors — that is, the hypothesis that resource mechanisms (data, financing, governance, and shared purpose) interact with reasoning mechanisms (trust, power dynamics, community voices, and equity) to produce positive outcomes.[31] Our study seeks to test and advance this hypothesis by improving understanding of how mechanisms for aligning relate to effective cross-sector alignment, improved equity, and sustainable alignment.

Effective Cross-Sector Alignment

Drawing on the cross-sector alignment theory of change, Lanford et al. define *aligning* "as a specific condition in which organisations [sic] in the healthcare, public health and social service sectors are sharing systems in each of the four core areas" of shared purpose, governance, finance, and data. As the authors explain, "Aligning in this sense can be contrasted with general collaboration, which does not require a particular cooperative structure."[32] By aligning cross-sector partners, ACHs are positioned to facilitate a systems-level approach to health improvement.

Improved Equity

Equity is both a process in and an outcome of aligning.[33] Past research shows that equitable processes promote equitable outcomes.[34,35] The World Health Organization defines *equity* as the "absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically."[36] The Georgia Health Policy Center further describes how equity "encompasses both health equity and racial equity and includes both processes and outcomes. It is widely acknowledged that addressing equity is a critical goal of aligning across sectors and, ultimately, critical for improving community well-being."[37] Our study assesses how equity within aligning efforts can act as a teaching mechanism for participants that leads to changes in mindsets and practices throughout the community.

Sustaining Alignment

Aligning is a continuous process that, when successful, leads to effective systems in which health care, public health, social services, and communities work together to better serve the needs of individuals and groups.[38] Because alignment is not an outcome to be achieved but rather a process that requires continuous monitoring, maintenance, and improvement, aligning efforts should be sustained long-term. When aligning systems for health, sustainability considers "the maintenance or improvement of resources, infrastructure, activities, outcomes, and relationships to affect community health over time."[39] A critical piece of sustaining alignment is *financing*, which is a key ingredient for successful aligning, especially when working at larger scales.[40] Past research shows that aligning efforts that have adequate financing to support staff, partners, and implementation of ideas are best positioned to transform systems.[41]

Local Context

Local context has the potential to influence every aspect of aligning. The Georgia Health Policy Center explains that local factors such as "geography, political will, socioeconomics, and community [needs]" influence how sectors align and that "individual, organizational, and system-level factors can enable or hinder progress to align across sectors."[42] As past research shows, local

context not only influences aligning processes, but it also contributes to aligning outcomes.[43,44] Scholars therefore suggest that organizations seek to understand and account for the local context in which they are operating as they work to align.

Our study focused on gaining an improved understanding of the interplay among context, mechanisms, and outcomes in ACHs. Realist theory suggests that outcomes are shaped by the context in which they are produced and the mechanisms generated through inputs, activities, and outputs of aligning participants.[45] Further, since we believe that "the mechanisms through which programs work will only operate if the circumstances are right,"[46] we paid careful attention to variation in outcomes at different times, in different places, and for different people so that we could develop a nuanced understanding of when and why collaboration dynamics produce effective alignment, improved equity, and sustained alignment. Two research questions guided our study:

- How can elements of an ACH's local context and aligning mechanisms be combined, enhanced, or mitigated to increase the likelihood of achieving effective cross-sector alignment, improved equity, and long-term sustainability?
- When do certain configurations work, for whom, why, and under what conditions?

Study Methods

Our research used mixed methods, a realist lens, and an engaged scholarship approach.[47,48,49] The Framework for Aligning Sectors,[50] Integrative Framework for Collaborative Governance,[51] and Common Framework for Assessing Accountable Communities for Health[52] guided our research question development, variable operationalization, and interpretation of findings.

Our study used a census sample of ACHs in the states of California ($n = 13$) and Washington ($n = 9$). We chose this sampling method to increase generalizability of findings and to ensure that the sample was large enough to produce reliable confidence intervals and detect significant effects.[53] The large ACH case sample let us conduct rigorous quantitative and qualitative analysis that shed light on broad questions about *when*, *what*, and *how much* regarding our variables of interest.

From the census sample, we selected a smaller, diverse sample of six ACH cases for a deep dive. We chose the cases using purposive sampling of heterogenous cases to give us a better understanding of the cross-sector alignment mechanisms, while also increasing the generalizability of our findings.[54] The resulting deep dive sample included two ACHs that serve rural counties (both in California), two serving urban counties (one in Washington and one in California), and two serving multicounty regions (both in Washington). These cases gave us the depth of information needed to investigate questions about why and how context and mechanisms lead to outcomes.

To collect and analyze evidence for our study, we used several sources and investigation methods. Our survey findings draw on 596 responses from individuals representing 20 ACHs. We also conducted interviews and focus groups with 85 individuals representing 15 ACHs. Additional data sources include meeting observations (n = 12), documents (n = 1,796), websites, and secondary data from the American Community Survey.[55] Table 1 provides an overview of group representation of the participants in our surveys, interviews, and focus groups.

Table 1. Group Representation of Study Participants

	Survey Respondents		Interview and Focus Group Participants	
Group Representation	*N*	%	*N*	%
Tribal representatives	11	2%	3	4%
Community representatives	61	10%	3	4%
Behavioral health	14	2%	5	6%
Public health	31	5%	7	8%
ACH staff	93	16%	40	47%
Health care	181	30%	13	15%
Social services	205	34%	14	16%
Total	**596**	**100%**	**85**	**100%**

Our analysis used descriptive and predictive techniques to explore the relationships among variables measuring local context, aligning mechanisms, and ACH outcomes. We analyzed quantitative data using structural equation modeling to understand the relationships among observed variables, latent variables, and multiple dependent variables.[56] Qualitative data were analyzed using process tracing to shed light on how resource mechanisms (data, financing, governance, and shared purpose) interact with reasoning mechanisms (trust, power dynamics, community voices, and equity) to generate outcomes.[57] This multipronged and mixed-methods approach mitigated issues of reliability and validity, thereby yielding accurate and useful information to help address the research problem at hand.[58]

Study Findings

Our findings demonstrate how local context and aligning mechanisms interact to produce outcomes in relation to our two research questions.

Effective Cross-Sector Alignment

ACHs shift practices by aligning diverse people and groups around a shared vision and accountability for community health. Overall, survey respondents reported relatively high perceptions of alignment in their ACH, with 89% of respondents agreeing that their ACH helps align resources and activities across community, clinical, and tribal partners (n = 463) and 95% of respondents agreeing that their ACH effectively provides support for collaboration among community, clinical, and tribal partners (n = 453). Findings across data sources suggest that cross-sector alignment is most strongly influenced by power dynamics, community voices, equitable processes, shared purpose, and shared governance. Additionally, we learned that perceived alignment was positively influenced by two elements of local context: population size and ACH staff size, meaning that the larger the population size and ACH staff, the more positively survey respondents viewed progress toward alignment in their ACH. Survey respondents' reported education levels had a negative influence on perceived alignment — that is, as education levels increased, perceptions of alignment decreased. Perceptions of alignment also varied significantly

by state; the geographic scale of the area served; and the survey respondent's race, group/sector representation, and ACH affiliation.

Our findings show that when ACHs effectively align sectors, diverse partners undertake joint projects, form new partnerships, and collaboratively plan across sectors. In some ACHs, cross-sector partners even worked together to successfully advocate for policy change. Improved alignment resulted in partners having a better understanding of their community health system, which helped all stakeholders work together as a cohesive system. This, in turn, made them better able to serve clients and reach their own organizational goals.

Improved Equity

ACHs are advancing equity in their communities by shifting mindsets, policies, and practices. Survey respondents reported relatively high perceptions of ACH progress toward equity, with 91% of respondents agreeing that their ACH applies principles of equity, diversity, and inclusion throughout its work (n = 467), and 90% agreeing that their ACH effectively promotes equity across their community (n = 451). Findings suggest that equity outcomes are most strongly influenced by community voices, equitable processes, trust, and shared data. Perceived equity was also positively influenced by two elements of local context: population size and density of the community served — that is, the larger and denser the population served by the ACH, the more positively survey respondents viewed the ACH's progress toward equity. Median annual income of the community served and survey respondent belief in systemic racism had a strong negative influence on perceived progress toward equity — that is, as community wealth and individual belief in systemic racism increased, perceived progress toward equity decreased. However, perceptions of progress toward equity varied significantly by respondent's race and group/sector representation.

Our findings show that with ACHs, aligning resulted in partners having increased capacity to equitably serve communities — especially marginalized, underserved, and disenfranchised communities. For example, ACHs increased partner capacity to understand health disparities and community needs by sharing data with partners. Through intentional and data-informed efforts to align diverse sectors and groups, ACHs improved, expanded upon, and increased accessibility of

services and resources for the people with the highest need. As a result, people and groups who most needed support were better served. In this way, aligning cross-sector efforts shows promise for improving outcomes for people who are most disadvantaged, which is a first step toward improving equity at the population level. Furthermore, the equitable practices that ACHs instilled in partner organizations during the aligning process hold promise for shaping communitywide practices that can improve equity at the system level.

Sustaining Alignment

ACHs are working toward systems-level outcomes that must be sustained over time for measurable progress to be made and maintained. Approximately two out of three survey respondents reported positive perceptions of their ACH's ability to sustain alignment, with 65% saying that their ACH was doing a lot to identify the financial resources needed to sustain its work (n = 160) and 68% saying that their ACH was doing a lot to identify a clear value proposition for sustaining its work (n = 174). Our findings suggest that sustainability is most strongly influenced by six mechanisms: community voices, equitable processes, trust, shared data, shared financing, and shared governance. Additionally, sustainability perceptions were positively influenced by two elements of local context: the population size of the community served and the amount of ACH startup funding received. Median annual income and population density of the community served had a strong negative influence on perceived sustainability progress; that is, as a community's wealth and density increased, perceived sustainability decreased. Perceptions of ACH sustainability varied significantly by the respondent's group/sector representation and the geographic scale of the area that the ACH served (e.g., neighborhood, city, county, or region).

At the time this research was conducted, the ACHs in the study had been leading their communities' aligning efforts for approximately five years. The ACHs that survey respondents thought were most sustainable were those that had a business or sustainability plan, that offered partners value or benefits from participation, and that adapted and responded to community needs. Our findings show that financing was only one piece of sustaining aligning, with joint resources being another critical component. For example, ACH partners worked together to develop new resources and identify ways to better leverage existing resources, such as ensuring that partners

and community members were aware of and connected to existing resources. As a result, partners valued participation in ACH activities and sustained their commitment to aligning across sectors over time.

Local Context

What works in one place and for one group of people may not work everywhere for everyone. Therefore, it is critical to understand *when* certain mechanisms work for different communities, *why*, and *under what conditions*. This understanding starts with an assessment of local context, which considers factors relevant to the target community. As our findings above show, local context influences aligning at the community, ACH, and individual levels. Influential elements of local context include community size, density, and wealth; ACH staff size and startup funding amounts; and ACH participant education levels and belief in systemic racism. Our analyses also showed that outcomes can be influenced by partner capacity to participate, ACH capacity to include community voices in aligning efforts, and an ACH's ability to coordinate with other ACHs and share resources such as tools, talent, technical assistance, and knowledge.

Discussion

Aligning occurs through a complex web of inputs and actions that together generate outcomes. Past literature points to the importance of local context, resource mechanisms, and reasoning mechanisms when seeking to align across sectors, but more research is needed to understand which mechanisms and elements of local context have the greatest influence on outcomes. Our study aimed to improve understanding of aligning by identifying ways in which local context and mechanisms can be configured or adjusted to increase the chances of achieving positive outcomes.

Our findings show that the framework's various mechanisms can work together to improve the chances of achieving particular outcomes. Our results also reveal that some mechanisms — such as using equitable processes in aligning activities — are associated with numerous positive outcomes. Further, our findings pinpoint the characteristics of local communities that can help or hinder progress toward outcomes. Organizations can leverage this granularity of understanding to

improve the chances of achieving effective cross-sector alignment, improved equity, and sustained alignment.

Our results support the hypothesis that resource and reasoning mechanisms interact with one another and local context to produce outcomes. This study builds on past research by exploring how known aligning mechanisms work together to generate outcomes and how those outcomes are simultaneously influenced by local context. We now know that when *seeking to align across sectors*, communities should prioritize —

- Monitoring and balancing power dynamics;
- Intentionally including community voices;
- Developing and using equitable processes;
- Ensuring that partners have a strong sense of shared purpose; and
- Building systems for shared governance across sectors.

When *seeking to improve equity*, communities should focus on —

- Integrating community voices into decision-making;
- Establishing equitable processes;
- Taking care to build trust among aligning participants; and
- Using shared data to monitor progress and guide decision-making.

When seeking to *sustain aligning efforts*, communities should emphasize —

- Including community voices;
- Ensuring equitable processes;
- Building trust;
- Using shared data;

- Developing shared financing approaches; and
- Developing systems for shared governance.

We also now know that greater population size, number of staff dedicated to aligning efforts, and startup funding amounts are associated with positive perceptions of outcomes. Conversely, higher education levels and belief in systemic racism among aligning participants, as well as income levels of the community served, are associated with negative perceptions of outcomes. Population density is positively associated with perceptions of some outcomes and negatively associated with others. With this improved understanding of how different mechanisms and elements of local context influence outcomes, communities can better prepare for successful aligning.

Limitations and Conclusions

Our study's multipronged, mixed-methods approach offered a strong foundation for inquiry. However, our work is not without limitations. Quantitative survey measures cover some portions of the framework better than others, and our study is limited in its ability to generalize findings to cross-sector aligning work outside the ACH model or our two targeted states (California and Washington). Also, because we conducted this study during a global pandemic that severely impacted local economies, individual health and well-being, and many other aspects of daily life, the COVID-19 pandemic almost certainly influenced our results.

As existing research shows, achieving cross-sector outcomes requires complex mechanistic configurations. If aligning is to produce positive outcomes, resource mechanisms such as financing, data, shared purpose, and governance must be intentionally paired with reasoning mechanisms such as equitable processes, trust building, balancing power dynamics, and integrating community voices. Furthermore, the local context of aligning efforts shapes how such mechanisms can be leveraged to realize positive outcomes. Our study captures some of our high-level research findings. You can learn more about results from Population Health Innovation Lab's research at https://pophealthinnovationlab.org/resources and read related research findings in the dissertation, *Linking Collaboration Dynamics and Outcomes in Collaborative Governance.*[59]

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Aligning Systems to Advance Health Equity in Texas: What Works, for Whom, and in What Circumstances?

Texas Health Institute

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The United States spends more on health care than any other country, and yet Americans live shorter lives and experience poorer health than people of other developed countries.[1] Health inequities, like health itself, are shaped by more than just health care — they are produced by the conditions in which people are born, grow, live, work, and age.[2] Efforts to align public health, health care, and social service sectors hold great promise for addressing these conditions and achieving greater health equity in the United States and Canada. However, we as yet have little knowledge or evidence about what works, how it works, and under what circumstances when aligning sectors to improve community health and achieve health equity. To address this, the Robert Wood Johnson Foundation (RWJF) Framework for Aligning Sectors focuses on identifying, testing, and sharing effective ways to align health care, public health, and social services to better meet the goals and needs of people and their communities. The framework has four core components: shared purpose, finance, data, and governance. These components drive alignment while the framework's adaptive factors — which are unique to each community and include trust, community voice, power dynamics, and equity — can enhance or inhibit alignment.[3]

Texas provides a unique learning ground to evaluate cross-sector alignment efforts for achieving health equity. The state has numerous collaborative efforts of various sizes operating across myriad locations, populations, health issues, and political and cultural contexts. Indeed, demographically, Texas is where the nation overall will be by 2050.[4,5] To our knowledge, however, we lack a comprehensive, realist evaluation of the breadth of health- and health-equity-focused cross-sector alignment efforts for Texas as well as for the nation as a whole. Our evaluation therefore sought to address four key questions:

- Which core components of the framework are reflected across Texas cross-sector alignment efforts for health equity, and how were those components developed?
- How is health equity defined, integrated, and measured across efforts, and how does it vary by context?
- What factors enable or inhibit cross-sector alignment across the four core components?
- What short, intermediate, and long-term outcomes have these efforts achieved, and how are they measuring success over time?

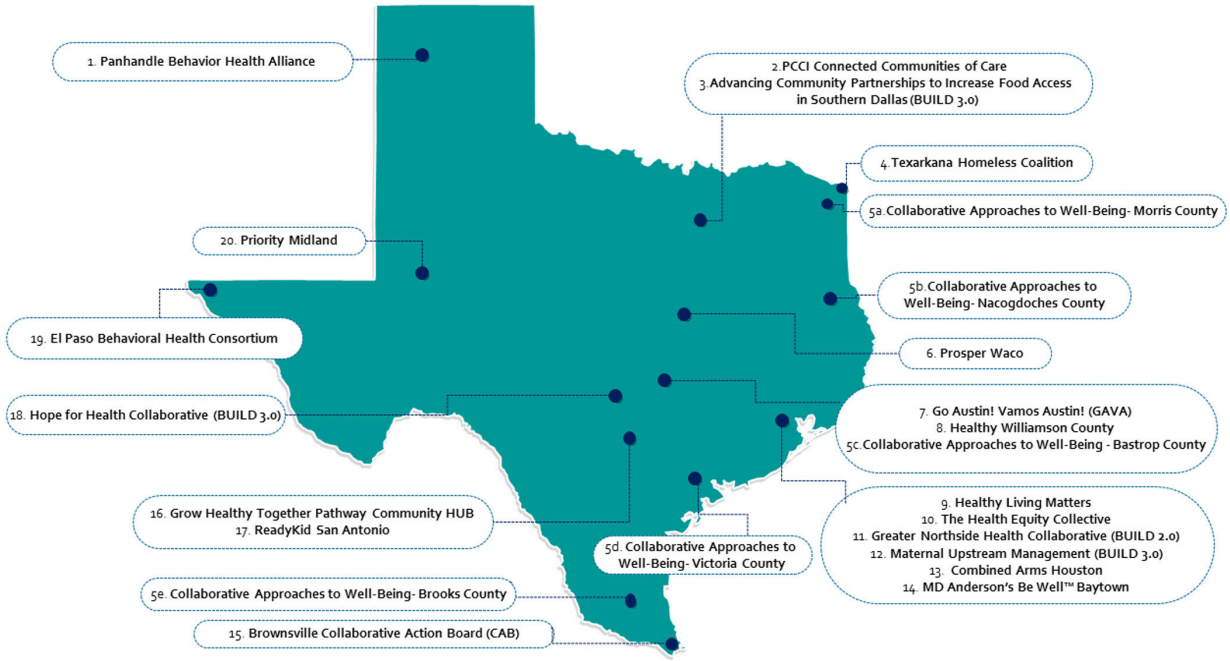
Methods

Our evaluation sought to fill a research gap by conducting a *realist evaluation* of cross-sector efforts for health equity, leveraging the wide range of Texas initiatives to test the framework across diverse contexts. Realist evaluation is designed to improve understanding about how and why different projects and programs work in different contexts.[6] Specifically, it seeks to identify how *contextual* (C) factors trigger particular *mechanisms* (M), and how this combination produces various *outcomes* (O). The Texas Health Institute was guided by Dr. Geoff Wong, a U.K.-based realist framework consultant.

Building on this framework and guided by a statewide steering committee of multisector experts, leaders, and community stakeholders, the Texas Health Institute collected information and data for this evaluation through four efforts:

- An environmental scan of health-equity-focused cross-sector alignment efforts in Texas;
- Key informant interviews with backbone leaders of 20 cross-sector efforts (here, backbone refers to organizations that led a cross-sector alignment effort);
- An online survey completed by 204 leaders and staff from partnering public health, health care, social service, and community organizations involved in cross-sector efforts; and
- Community focus groups with 136 participants across five selected communities that have well-advanced cross-sector efforts.

Figure 1. 20 Cross-Sector Alignment Efforts Focused on Health Equity Across Texas.



The map shows implementation of the Collaborative Approaches to Well-Being in Rural Texas across five counties. For the purpose of this evaluation, we assessed the overall initiatives.

Findings

Our evaluation identified the contexts and mechanisms that facilitate the development of the four core components of cross-sector alignment efforts to improve community health and achieve health equity. We now describe our findings for each component.

Shared Purpose

An agreed-upon, well-defined purpose helps cross-sector alignment efforts maintain focus and drives shared priorities, goals, and objectives.[7] All 20 cross-sector alignment efforts in this evaluation recognized the importance of a shared purpose, and 85% of coalition partners said that

their collaborative established a set of priorities and goals. The findings revealed that the main facilitators for developing a shared purpose were a desire to align efforts, a collaborative history, and an urgent need in the community. Cross-sector alignment efforts advanced toward developing a shared purpose when there was trust, a dissolution of self-interest, and buy-in from partnering organizations.

Realist Synthesis: *When community leaders, policymakers, and decision-makers agree on a set of priority issues and their urgency (C), they are more likely to be able to articulate a shared purpose, mission, and vision (O) because differences have been resolved (dissolution of self-interest) (M)*.

A key informant emphasized this as follows: "I'll say the one thing I think is most important is dissolution of self-interest — so we are not there for ourselves. It is incredibly important." Ongoing communication of this shared purpose with partners and community members allowed cross-sector efforts to maintain a focus on priorities, while ambiguities around purpose hindered progress. Shared purpose played a foundational role in developing governance, data, and finance as it informed and guided decisions around how each structure should progress based on goals and objectives.

Governance

Governance provides the "means to steer the processes that influence decisions and actions."[8] While 46% of survey respondents indicated that their cross-sector effort had strong governance structures, it was often a work in progress — even for the most mature efforts. Our evaluation identified a number of important facilitators for strong, shared governance, including the leadership of a backbone organization in convening and coordinating alignment, shared agreement on priorities among partners, clear roles and responsibilities, and equality across partner voices. All such factors were integral to balancing and sharing power across different organizations and with community partners. We also found factors that inhibited the development of effective governance structures, including varying definitions of success, limited capacity, competition

between organizations, and changes in leadership.

We found that governance structures often develop after a shared purpose is established; such structures then serve to drive priorities and objectives. Further, we found a complex relationship between governance and finance structures: While finances may not directly influence the development of governance structures, those structures seem to influence both financial and long-term sustainability.

Shared Data

Successfully addressing complex social issues requires the ability to measure community-level needs and outcomes, track changes over time, and share this information between partner organizations and with the community. In our evaluation, data sharing ranged from shared community health needs assessments and community reports at the rudimentary level to complex interoperating systems of social, economic, and health data shared by cross-sector partners.

Our findings revealed that many cross-sector efforts struggled to develop shared data systems and processes. Only 32% of partners indicated that they had well-developed shared data systems. Nearly 45% of partners reported that the primary factor for developing shared data systems was a desire to align common efforts. Once data was leveraged to develop a shared purpose, cross-sector efforts recognized the need for continued data sharing as a way to measure progress toward goals, transparency, and accountability to funders and community members.

The primary inhibitors of shared data systems were interoperability barriers, limited capacity, and disagreement on data interpretation. Our findings further showed that data sharing is less likely when efforts lack explicitly agreed upon data sharing processes that allow all organizations equal data input and ownership.

Financing and Sustainability

Financial stability and sustainability directly affect the extent to which a coalition can achieve its objectives, expand its reach, and maintain operations over time. While we found that seed funding most directly influenced the advancement of shared purpose, governance, and data, financial sustainability was the most underdeveloped component across the cross-sector alignment

efforts. Only one-quarter of partners indicated that their cross-sector effort had a strongly established financing system. Notably, nearly 21% of partners reported a lack of knowledge about their cross-sector effort's financial structures and processes, suggesting that decisions about financing may be concentrated among a few leaders.

The top factors contributing to overall sustainability included dedicated staff, availability of long-term funding, and a demonstration of progress and success. Currently, the majority of the cross-sector alignment efforts are funded through grants or donations that started with some type of seed funding. Coalitions justified their existence by demonstrating success and progress to both funders and community members. Inhibitors of sustainability included limited funding, competition, and staff turnover.

Trust and Power Dynamics

Creating and maintaining trust requires that coalitions both understand and balance the power among organizations and with community members. We found that when partnering organizations and community members were able to influence and impact the cross-sector effort's outcomes, they were more likely to support it because they believed that their contributions were valued and that the effort was invested in their benefit. Informants indicated that having an equal voice in decision-making and ongoing processes of engagement were keys to building trust and power with both community members and partners.

Realist synthesis: *When coalitions have consistent processes of engagement, data sharing, and ease of access to resources and programs (C), community members are aware (O) and more likely to trust the organization (O) because of the credibility and transparency it offers (M).*

Emphasizing this, one key informant noted that "it does begin with your relationships and trust, building on that, nurturing those relationships, nurturing that trust at multiple levels within the organization. That was key for us — continued communication and engagement." Indeed, our evaluation showed that a positive history with both community members and partnering organizations contributed to maintaining trust and facilitated alignment activities. Moreover, when

coalitions were able to demonstrate early successes and show that they could keep their promises to the community, community members in turn showed greater buy-in and trust, resulting in increased support for alignment activities

Community Voice and Equity

Having a shared understanding of the root causes of the health and the social needs of a community enables cross-sector alignment efforts to address factors that create these needs and issues.[9,10] Two-thirds of partnering organizations indicated that health equity was an explicit high priority for their collaborative. Of the cross-sector alignment effort activities related to health equity, the majority involved elevating community voice. Almost 70% of organizational partners indicated that their cross-sector effort was working to advance health equity through active community engagement, while 56% were operationalizing health equity through community-centered interventions. Examples of these activities included involving historically marginalized communities in decision-making, creating access to health care and resources, and combining disaggregated data with lived experiences to tailor interventions.

Realist synthesis: *When coalition leaders and members take the time to recognize the needs of historically marginalized communities (C), the alignment is more likely to address health equity issues (O) because the coalition is willing to use its powers to elevate these issues (M).*

Emphasizing community voice has powerful benefits, as this organizational partner described: "Our commitment is to really work with residents to elevate their voice and in many ways remind them that they have the power to make change as we did." Nonetheless, our evaluation found a need for continued work on and improvements in community engagement and empowerment. Many community members expressed limited awareness of the services and programs that the coalitions provided; others indicated that they felt unheard by leadership and wanted to provide feedback about their community's "true" needs.

Outcomes and Measures of Success

Although the vast majority of alignment efforts had yet to establish measures of success, those that had established performance indicators typically monitored the progress of health impact across programmatic, community, and population levels. While the framework posits changes in practice, policy, and mindset as short-term outcomes, in practice, our findings suggest that changes occur at other levels as well. We also found that the framework may not capture the nuanced ways and areas in which change occurs.

The cross-sector efforts we studied studied typically identified examples of short-term outcomes in four areas:

- Development of core components and adaptive factors;
- Interorganizational progress in areas such as trust building, new relationships, and shared progress;
- Organizational progress in areas such as capacity and skill improvements due to the collaborative efforts; and
- Community-level progress in areas such as developing new partnerships with community leaders, organizations, and members.

Common intermediate outcomes included the development of coordinated systems, demonstrated progress, and effective partner "synergy." As with short-term outcomes, our findings on long-term outcomes also suggest additional dimensions beyond those covered by the framework; these include the following:

- Improvement across intervention-level outcomes, such as changes in emergency department visits or service utilization;
- New policies and systems, along with changes in mindset; and
- Improved population health outcomes and improved conditions in the community.

Discussion: Lessons Learned and Future Considerations

Our evaluation revealed that implementing cross-sector alignment efforts requires a substantial investment of time, resources, capacity, and finances. Following here are the four key takeaways from our evaluation, which can provide guidance to community leaders, practitioners, and funders leading and implementing cross-sector alignment initiatives to advance health equity in their communities

Cross-Sector Alignment for Health Equity Is a Long-Term and Bidirectional Undertaking

> **It is the investment of our partners in ensuring that we are learning from the data and we are collecting together to better inform policy and process where the eventual return on investment is additional funding for gaps in service. —Key informant**

Our evaluation reinforced the fact that aligning systems across health care, public health, and social services is not a one-time project but rather a long-term undertaking that requires time, investment, and resources at multiple levels. Even prior to infrastructure development, coalition leaders must invest effort in building consensus, trust, relationships, and buy-in from both community members and partnering organizations. Then, throughout the alignment process, structures for shared purpose, governance, data, and finance continuously evolve and influence one another and are further influenced by community voice, trust, equity, and power dynamics. Finally, as efforts achieve their set outcomes and objectives, these in turn influence the core components and factors in a bidirectional pattern (feedback loop).

Because the alignment process is a long-term endeavor, community leaders hoping to engage in this collaborative work should consider a *phased approach*. Taking a strategic, phased approach to alignment allows both practitioners and funders to understand the stage (or stages) of

development that they have the capability to support.[11,12] Additionally, organizations that provide initial funding should work closely with individual alignment efforts to "build bridges" to long-term sustainability.[13,14,15]

Building and Maintaining Trust With Partners and the Community Is Foundational

> **I think what would build trust is to say that you are proposing a project and ensure that it is completed quickly. Then people would say, 'This collaboration is working.' The community will become engaged. They would see that you are doing something for them, and they would support you. That is how you build trust, because sometimes people say they will do something, time passes, but nothing gets done. —Community member**

We found a clear consensus among both collaborative partners and community members that *trust* played a foundational role in many programmatic and developmental activities leading to cross-sector alignment. Trust between community and collaborative partners can impact the extent of mutual buy-in and engagement, the development of core components, and progress toward equity and intended outcomes. As such, developing trust is a priority, yet it is also a challenge.

Trust among organizational partners follows a cyclical nature of taking risks, meeting expectations, and growing in vulnerability (trustors being dependent on trustees).[16] Because collaborative history and early wins facilitate trust, coalitions should work to leverage existing relationships with partners and set realistic, intermediate goals.

Our findings show that trust with community members was often developed through prior positive history between the community and participating organizations, through demonstrating early wins, and through accountability and transparency. Starting points for developing trust with community members included empowering community members through ongoing engagement (especially in decision-making), identifying community leaders and champions, and tailoring communications for the target community to facilitate meaningful engagement. Funders can

advance this process by building grant requirements to specifically involve community leaders and members.

Centering Equity in the Alignment Structure Is Necessary to Achieve Equity in Outcomes

In our evaluation, a majority of the collaborative partners indicated that health equity was an explicit, high priority for their cross-sector effort, but many had yet to establish definitions, language, and shared measurements around equity. Cross-sector alignment efforts should work to formalize principles, common language, measurements, and training across partners to center equity. A starting point for centering equity is to explicitly identify issues of social and structural injustice in the collaborative's mission and vision. Incorporating equity language in the strategic vision, plans, and official agreements makes equity a binding goal and helps partners hold themselves accountable to it.[18,19] Other examples for centering equity in cross-sector work include having diverse representation in places of decision-making, creating shared data systems with disaggregated data, and identifying financial means and strategies focused on addressing social and structural injustice.[19] One key informant said that their effort prioritized equity through and beyond other priorities:

> **We really wanted to make health equity in the forefront — or actually [have equity] go through all of our top five health priorities so it's not necessarily a top priority, but it transcends all of them. —Key informant**

At the community level, programs and health care practitioners can incorporate equity into their work by developing a shared understanding of terminology, data, and history with community members and partnering organizations. Rather than solving problems *for the beneficiaries* of the initiatives, leaders should approach the beneficiaries (most often, community members) as assets and partners in codesigning community-based, community-led solutions.[19]

Cross-Sector Alignment Efforts Will Benefit From National and State "Communities of Practice" and Infrastructure Support

> **We bring [the collaboratives] together twice a year for opportunities of shared learning. And, as a part of that, they can actually talk about what is happening in their communities, on the ground, and they can actually brainstorm ideas with each other. And then we also bring them together for what we call our 'Community of Practice,' where they can actually talk monthly with each other and learn from what the other counties are doing. —Key informant**

In our evaluation, cross-sector partners expressed the need for guidance, exchange of information, collective learning, and access to resources to assist them through the process of aligning cross-sector efforts. As the national coordinating center for the RWJF Aligning Systems for Health initiatives, the Georgia Health Policy Center (GHPC) has the opportunity to establish itself as a formal community of practice. As such, GHPC would strive to bring together a diverse community of cross-sector collaborative leaders, policymakers, practitioners, funders, community members, and other stakeholders at national and state levels to exchange ideas for improvement and implementation, as well as provide infrastructure support. Through such communities of practice, intermediaries could provide key assistance in several ways:[21]

- Offering training and technical assistance to assess needs and provide ongoing support to individual sites;
- Holding convenings to connect stakeholders nationally and at a state level;
- Using web-based tools and platforms to create an online community for exchanging ideas, resources, and networking; and
- Shining a spotlight on designated sites to increase the visibility of cross-sector alignment efforts.

By connecting networks of organizations with similar interests and a common agenda, funders and intermediaries can broker new relationships leading to further alignment efforts. By aligning cross-sector collaboration in an efficient manner, collaborators can increase the scale, enable more effective processes, further sustainability, and ultimately make system-level progress toward achieving health equity.[21]

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If You Build It, They May Not Come: Adopting a Community Resource Referral Platform Among CBOs

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Greater focus on value-based health care, combined with abundant evidence of how social factors impact health outcomes, has led stakeholders across the health care sector to investigate ways of addressing patients' social needs, thereby improving their health outcomes, reducing health disparities, and controlling cost growth.[1,2,3] As part of these efforts, many health care organizations — and particularly those in large health care systems — have contracted with third-party software vendors to provide up-to-date directories of local social service resources and make and track electronic referrals to these resources. Examples of community resource referral platforms include Findhelp (formerly Aunt Bertha), Good Grid, NowPow, Unite Us, and WellSky (formerly Healthify).[4,5]

Ideally, these platforms can help organizations across a range of sectors coordinate services for their common clients, thereby improving client outcomes and system efficiency. By tracking service needs and referral outcomes, these platforms can also provide valuable data for service planning and policymaking. However, despite the enthusiasm for the platforms among health care organizations, many questions remain about whether the tools can live up to their promise. A major challenge is that their usefulness as a tool for cross-organization service coordination depends on adoption and participation by social service organizations (SSOs), including community-based organizations (CBOs) and local government agencies. In previous work,[6] the Social Interventions Research and Evaluation Network (SIREN) found that it was challenging for health care organizations to convince CBOs to use these platforms. However, at that time, we were unable to investigate the perspective of SSOs. Additionally, to our knowledge, no research had yet tested strategies to overcome barriers to platform adoption or use among SSOs.

To fill these knowledge gaps, we conducted a mixed-methods study of the implementation of a community resource referral platform, NowPow, in Trenton, N.J., between 2020 and 2022. NowPow is a software tool that provides a regularly updated, searchable community resource directory. It also lets users capture data about client needs, generate a tailored shareable list of resources that address client needs, and send electronic referrals between organizations to initiate service requests. Trenton Health Team (THT), a nonprofit focused on improving community health in Trenton, began implementing NowPow in February 2019. This implementation was aimed at addressing the need among local service providers for an infrastructure to facilitate cross-sector referrals and service coordination. To implement NowPow, THT worked with local social service

and health care organizations to develop agreements and protocols for how NowPow would be used in Trenton. Based on the enthusiasm about the tool, THT also subsidized the cost of NowPow so that it was free to all local organizations. Despite these efforts, one year into implementation, few of the 27 organizations that had committed to adopting the tool when it launched were using it regularly.

To improve uptake of the platform and expand knowledge about CBO perspectives on community resource referral platforms, THT partnered with SIREN researchers to (1) identify Trenton CBOs' barriers to using NowPow and (2) test the impact of strategies to increase their NowPow use. This chapter describes what we did and what we learned.

Methods

Our study took place in three phases between spring 2020 and summer 2022. In the first phase, we conducted 28 key informant interviews with front-line staff and leaders at 16 Trenton CBOs to understand barriers and facilitators to platform use. We used a maximum variability sampling approach, selecting organizations for interviews that represented a range of baseline NowPow use, sectors (e.g., housing, family supports, education, food, and health), and organization size. For each organization, we sought to recruit at least one front-line staff member and one manager or leader. We offered organizations $100 compensation for their participation. Because we also wanted to learn from other communities' experiences with engaging CBOs in platform use, we complemented this local data collection by interviewing people at 11 organizations outside of Trenton, which we identified through recommendations from colleagues in the THT and SIREN professional networks. We also convened a project advisory committee composed of national experts on health care–CBO partnerships and Trenton community stakeholders.

In phase 2, we identified seven strategies that were feasible to implement and would plausibly facilitate Trenton CBOs' use of NowPow based on our phase 1 interviews and recommendations from our advisory committee and THT's NowPow Steering Committee (local CBO representatives that advise THT on NowPow implementation). We then used a survey of Trenton CBO staff and leaders to narrow the list to four strategies: monthly data reports, a centralized referral hub, tailored training, and a communications campaign.

In phase 3, we implemented the four strategies sequentially (but with some overlap) for three months each from June 2021 to April 2022. The first three were implemented for different sets of organizations based on the likelihood that they would respond to the strategy. We implemented the communications campaign, which was intended to reach all organizations, after the other three strategies. To understand the strategies' impact, we conducted key informant interviews at 21 organizations with individuals who had been exposed to at least one strategy within the previous three months. The interviews were semistructured and asked about the participant's reactions to the strategies and how or if they impacted NowPow use, as well as asking for general feedback on how THT could increase NowPow use among CBOs. Three of our team members (Cartier, Burnett, and Fichtenberg) analyzed the interview transcripts to identify themes. Because it was a program evaluation, our study was considered exempt from review by an institutional review board.

Phase 1: Findings

Platform Value to CBOs

The resource directory was by far the most valued part of NowPow among the organizations we spoke with, as the directory targeted a clear need: identifying resources to help address clients' needs. Users also appreciated having various ways to easily share resource information with clients (e.g., through a printout, a text, or an email). Some also liked the ability to remind clients about resources. In contrast, only a few interviewed users took advantage of the platform's ability to send referrals electronically (e-referrals). The few who did said that the e-referrals saved them time and helped ensure that the partner agency would follow up with their client. Very few users mentioned using the platform's needs assessment/screening functionality.

Barriers to Platform Use

As Tables 1 and 2 summarize, the phase 1 interviews revealed potential barriers to platform use (Table 1) and organizational and staff factors that seemed to affect NowPow use (Table 2).

Table 1. Barriers to Platform Use

NowPow did not provide enough benefit	Most organizations already had processes to make referrals, such as via email, phone, or fax, that they had developed and honed over time. As a result, NowPow did not provide enough added value. In addition, a number of organizations were using client-management platforms (e.g., HMIS) — often as a requirement of funding — that made NowPow feel duplicative.
Lack of interest in or comfort with making e-referrals	This barrier included situations in which staff wanted to vet the organizations first or preferred to do a warm handoff over the phone to make sure the connection happened; it also covered situations in which staff members preferred to have clients reach out to resources themselves as part of supporting their self-sufficiency.
New tool fatigue	Several interviewees mentioned that they felt overwhelmed with the number of possible technology tools they could use in their work and didn't know which to prioritize.
Lack of time and capacity	A number of users mentioned the lack of time or staff capacity needed to learn how to use the tool.
Low comfort with technology	Some organizations, particularly smaller ones, had staff members who were not very comfortable with technology. This slowed platform adoption.
Lack of understanding of the platform's capabilities	Several interviewees were not aware of NowPow's ability to send and track referrals. Their interest in the tool increased when they heard about this functionality.
Platform limitations	Some interviewees who had used the platform found that it didn't quite meet their needs. Limitations included lack of resources for specific subpopulations (e.g., immigrant populations) and lack of coverage outside the city of Trenton.
COVID impacts	A number of organizations mentioned that they had just learned how to use NowPow when COVID hit and, in the chaos that followed, were not able to focus on using the new tool.

Table 2. Possible Organizational and Staff Factors Impacting NowPow Use

	CBO or staff are MORE likely to use NowPow if:	CBO or staff are LESS likely to use NowPow if:
Organizational factors	• The CBO makes referrals, especially for a variety of services, or wants to increase referrals to their services • The CBO needs to track referral data • CBO leaders make it a priority • Its use is required as part of a program or grant	• The CBO doesn't make many referrals or refers only to a few organizations (and always the same ones) • The CBO does not need to increase their volume of incoming referrals • The CBO already has a similar system (e.g., HMIS, Good Grid, Apricot, ETO, etc.)
Staff factors$	• The staff members making referrals are new to Trenton or don't know its organizations very well • Staff members are comfortable with new technology	• The staff members making referrals are familiar with Trenton organizations • Staff members prefer to make warm handoffs (e.g., over phone) • Staff members want to promote self-sufficiency among clients • Staff members don't like or are uncomfortable with new technology

Monetary Incentives for Use

In our phase 1 interviews, we asked interviewees whether small monetary incentives for using the platform would be effective. We expected to hear a positive response, given that lack of resources was a barrier to tool adoption. However, interviewee reactions ranged from discomfort to outright opposition to the idea. Interviewees did not like the idea of staff members or organizations being financially rewarded for logging into the platform or using it to make referrals. They said that if it was in a client's interest, they did not need to be incentivized to use it — and if it wasn't in the client's interest, then they shouldn't be using it.

Phases 2 and 3: Identifying and Testing Strategies

Among the strategies identified based on the phase 1 interviews, the following four strategies were ranked highest in the CBO survey and selected for testing.

Strategy 1: Monthly Data Insight Reports

THT staff developed these reports to provide data about an organization's use of NowPow in the past month, including end-user platform activity and the most common types of resources shared with clients and involved in e-referrals. Reports included trends over time and compared the organization's use of NowPow with its use by other organizations. The reports, which we sent to end users and team managers, were intended to remind CBO staff about NowPow and to demonstrate how it could generate data about clients' needs that could inform CBO programming. We sent the monthly reports to a total of 29 people at 10 diverse organizations for four months (June–September 2021).

Strategy 2: Centralized Social Needs Screening and Referral Hub

The referral hub was designed to help CBOs that lacked the staff to use NowPow's resource search and referral functionalities. The referral hub let these organizations use NowPow to refer clients to THT, where staff members would reach out to these clients to assess their needs and make the appropriate referrals. We offered use of the referral hub to three organizations; two accepted. The hub operated for three months (August–October 2021).

Strategy 3: Intensive Tailored Trainings

We designed this strategy to increase understanding of NowPow's potential value and thereby increase buy-in for platform use among CBO program managers and front-line staff. The training was also intended to help CBO staff think through how to incorporate NowPow into existing workflows to increase its use following the training. This intensive tailored training expanded the trainings that THT staff had previously provided to new users in three ways. First,

it added a preliminary conversation with the CBO's relevant team leader and (if possible) a senior leader. The goal of this conversation was to introduce the platform's features, identify how it could support team and organizational goals, and discuss how it could be integrated into existing workflows. Second, it added a discussion of workflow integration into the end-user training. Third, one month after the training, we sent a snapshot of the team's platform use (similar to the data insights report, but shorter) to the team leader to give them a sense of how their team used the platform, as well as how frequently they used it. We offered this intensive tailored training to five organizations over five months (August–December 2021).

Strategy 4: Communications Campaign

We designed the communications campaign to help communicate NowPow's value to Trenton CBOs and to help create a stronger shared interest in NowPow among these organizations. The campaign involved a series of seven emails featuring video and written testimonials about NowPow from THT and local CBO users and leaders. We sent the emails to every person who had ever received a NowPow onboarding training. We also held two virtual meetings — one with CBO leaders, and one with front-line staff/NowPow end users — to discuss the tool's collective value for the Trenton community. The communications campaign ran for three months (mid-January to mid-April 2022).

Phase 4: Assessing Strategy Impacts

Data Insight Reports

Although we were unable to track email open rates for our first report (due to how it was sent out), we tracked open rates for the second through fourth reports. For these three reports, we found an average open rate of 27%, indicating that the reach of our data insights reports was relatively low. We interviewed nine people who opened at least one report and, based on their comments, found that the reports basically confirmed what they already knew about their organization's NowPow usage — that usage was fairly low. However, several interviewees said that the reports were useful reminders about NowPow and recommended that THT continue sending them, but

do so quarterly, rather than monthly. Two interviewees said that receiving the reports led them to take actions to increase NowPow use among their staff. These actions included assigning a staff member to lead NowPow implementation in their organization and increasing communications about NowPow with their team.

Referral Hub

Neither participating organization saw the referral hub as useful, although each had different reasons. One — a homeless services organization — had pre-existing on-site partnerships that enabled them to quickly refer their clients in person. The other found NowPow's e-referral functionality easy to use and therefore felt that they didn't need extra support in making referrals. Also, both organizations were small CBOs that had many competing demands and rapidly shifting priorities during the referral hub pilot that affected how the hub worked in practice.

Tailored Training

We interviewed three people (at three different organizations) about the trainings, and all three reported positive perceptions of the trainings, especially for the hands-on aspects of it. Interviewees also appreciated the data snapshot sent one month post-training, as it allowed managers to see if their trained users were using the platform and to follow up with staff members if that usage was lower than expected.

Communications Campaign

The open rates for the communications campaign emails were low, and view rates of the videos were even lower. Confirming this, our seven interviewees — including those who email analytics showed actually did open the emails — reported low awareness of the communications campaign emails and videos. The high email volume, the mass nature of the emails, and the feeling that the email content was repetitive, all contributed to respondents not reading the emails carefully, if they opened them at all. In contrast to the low engagement with mass emails, attendance at the leader and staff convenings was high (28 and 41, respectively) and attendees expressed appreciation for NowPow and especially for its resource directory.

Discussion

Despite selecting strategies based on end-user perspectives, none of the four strategies we tested — that is, the monthly data reports, a referral hub, tailored training, and a communications campaign — seemed to impact reported NowPow use. However, the data reports did prompt some managers to examine NowPow use among their teams, and the tailored trainings were well received. Barriers to the use of NowPow and even the resource directory (its most valued functionality) included the existence of other, similar tools that organizations were already using or required to use; the lack of need to look up resources for clients (often because staff were already familiar with local resources); and the activation energy needed to learn how to use a new technology tool, especially for staff members who were less comfortable with technology. At the same time, in both the phase 1 and phase 3 interviews, many of the individuals we spoke with expressed enthusiasm about NowPow as a concept, and our interviews in some cases renewed interest in NowPow and spurred individuals to ask for refresher trainings. This disconnect between expressed interest in NowPow and its actual use may reflect the fact that, in Trenton, NowPow didn't provide quite enough value to overcome the barriers to adoption that exist for any new tool. Alternatively, it is also possible that achieving widespread use of a tool like this simply takes time, especially when a worldwide pandemic interrupts the adoption process. This second possibility is supported by the fact that after a dip in 2020 following the COVID pandemic, NowPow usage is trending slowly upward over time.

One of our project's key learnings was that organizations and staff members varied widely in their reactions to the tool. The platform seemed most valuable to organizations that provide referrals to clients who have a variety of needs, as this requires a wider variety of resources compared to organizations that typically refer clients to the same few resources. Within organizations, the platform was most appreciated by staff members who were new to the community and unfamiliar with local resources.

Another key project learning was that CBOs valued the platform most for its resource directory and the ability to easily share resources with clients, but not for its e-referral or needs-assessment functionalities. Given that the major driver to implement these platforms is the health care sector's interest in documenting referral outcomes, this is an important finding for platform

developers and purchasers to consider.

Our findings also indicate that organizations seeking to promote CBO adoption of community resource referral platforms may face an uphill battle, even if they can subsidize the platform's cost, promote the tool, and provide support for CBOs to start using it. This is likely to be particularly true in smaller communities like Trenton, where staff members are typically familiar with local resources and may prefer email or phone referrals. In larger communities, the tool may provide more intrinsic value.

Although our phase 1 interviews indicated that paying CBOs to use the platform was unlikely to be effective, we asked only about small monetary incentives. It is possible that larger payments — for example, payments large enough to fund a staff person to manage the platform for the organization — could incentivize use. Still, unless these tools provide obvious, substantial mission-aligned value that clearly enhances their ability to serve their clients, CBOs are unlikely to widely and easily adopt the tools. More generally, to the extent that cross-sector alignment requires doing things differently and adopting new processes and tools, our findings highlight the importance of building on existing processes and making sure that new approaches provide a clear — and large-enough — mission-related benefit for each partner in order to help overcome the barriers to change that inevitably arise.

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The SHERO Study: Understanding Rural-Urban Differences in Cross-Sector Alignment in Two Kentucky Communities Serving Pregnant and Parenting Women in Recovery

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Substance use affects individuals, families, and communities, and while various programs seek to facilitate access to substance use treatment, multiple barriers persist. The ongoing opioid epidemic and an increase in overdose deaths during the coronavirus pandemic[1] has complicated this already challenging issue. It has also had an impact on mothers and their children: Prenatal substance exposure has directly impacted both neonatal outcomes and infant-child health and development, while indirect effects of substance use can adversely affect parenting skills and disrupt the family unit.[2,3] These direct and indirect impacts are influenced by social factors — such as housing, safety, and nutrition — that the traditional health care delivery system may not address.[4,5]

In 2020, there were 1,965 drug overdose deaths in Kentucky, 81.1% of which were opioid-related (a rate of 37.9 deaths per 100,000 persons).[6] By comparison, the national age-adjusted rate of overdose deaths was 28.3 deaths per 100,000 persons, 74.8% of which involved opioids.[7] Beyond opioid addiction, rates of drug and alcohol dependence in Kentucky remain at or slightly lower than the U.S. average.[8]

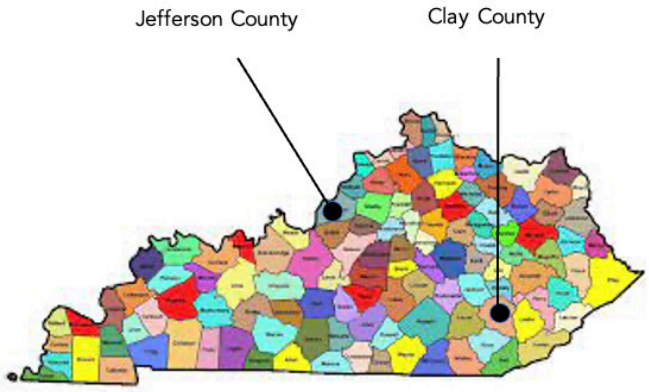
Women face particular challenges when it comes to substance use and treatment. In the United States, 5.8% of pregnant women reported use of illicit drugs in 2019.[9] Black and Hispanic women are less likely to receive substance use and mental health treatment services.[10,11] A 2012 study focused on pregnant women seeking substance use treatment in rural Kentucky found that more than 80% experienced barriers to treatment.[12] For pregnant women seeking substance use treatment, the availability of local treatment facilities and social services may be insufficient to ensure access to needed services. These women also face multiple barriers to care, including fear of prosecution or loss of custody of their children, lack of support for children and other family responsibilities while in treatment, and the stigma associated with drug or alcohol use during pregnancy.[12,13]

The opioid epidemic has highlighted the fact that substance use impacts more than the individual and requires collaboration between systems of health care, public health, and social services to address the complexities of related disorders.[14] Successful recovery depends on the cooperation of organizations that address social determinants and root causes, including legal issues, housing, food, child care, and other health and social support services. Communities seeking to eliminate health inequities rely on multisector partnerships to address underlying causes — including poverty and discrimination — to ensure that every person has the opportunity to be

healthy.[15] Such collaboration and system alignment in a network of health care, public health, and social services becomes even more imperative when a woman is pregnant or parenting other children; these women may also need multidisciplinary services, such as early intervention or educational services.

Freedom House, an evidence-based residential, licensed clinical treatment program, serves as a model for providing substance use treatment to pregnant and parenting women. Established by Volunteers of America Mid-States (VOAMID) in Louisville, Ky., in 1993, Freedom House currently has three locations in metropolitan Louisville (Jefferson County) and one in rural Manchester (Clay County) (see Figure 1). Freedom House programs treat mothers' substance use disorder, promote the birth of healthy babies, reunite families, and reinforce positive behavior changes. Recognizing that the entire care system, or network of providers, is the context that influences outcomes, Freedom House prioritizes organizational partnerships, including with the family court and justice system, other substance use treatment programs, parenting programs, health care providers, child care providers, local health departments, the state child protection agency, faith-based programs, and legal assistance organizations.

Figure 1. Locations of Jefferson and Clay Counties in Kentucky



Our Strengthening Health Equity in Recovery Outcomes (SHERO) study measured and described the context surrounding cross-sector alignment within two community networks in Kentucky. Each network included health care, public health, and social service organizations, including VOAMID Freedom House, that serve women, children, and families impacted by substance use. Further, we explored the association between interorganizational alignment and collaboration on maternal outcomes and successful program completion in VOAMID Freedom House. Our analysis of interorganizational networks provides an empirical understanding of how specific organizations partner or align and is used to describe the network as a whole (instead of the

individual organizations within it).[16] Stronger service delivery networks can coordinate activities and improve outcomes for clients.[17] As networks evolve and mature, organizational partnerships and their related collaborations may improve capacity for service delivery and result in strengthened connections and more sustainable collaboration.[18]

Research on service delivery networks is growing. Prior work indicates that network density — that is, the ties between network organizations — can increase over time.[19] Denser networks may have more pathways for exchanging information and sharing resources.[20] DiMaggio and Powell suggest that when networks promote interorganizational development and learning, they are more likely to produce positive outcomes.[21]

While previous work has described the networks that serve women with substance use,[22,23] it offers limited empirical evidence on the structure or relationship between organizational collaborations and outcomes in this context. One study examined community care networks, which included five integrated treatment programs for pregnant women. While cross-sector partnerships existed, the strength of the partnerships varied based on partner type, and the impact of these structures on outcomes was not analyzed.[24]

The SHERO Study

The SHERO study had two overall objectives. First, we wanted to measure overall and cross-sector alignment across health care, public health, and social service organizations in the two community-based systems through which VOAMID Freedom House provides care to women and families. Second, we wanted to examine and describe implementation variations in the two communities, with the goal of explaining different network characteristics and the presence or absence of cross-sector alignment.

Community engagement was core to the SHERO study's work. To support this, we emphasized three key strategies: (1) partnering with VOAMID as a community research partner, and including its support staff and Freedom House graduates as part of our research team; (2) engaging a community advisory board (CAB) in our study's design, implementation, translation, and dissemination; and (3) engaging Freedom House clients and graduates to help us define the networks.

Methods

To identify key organizations serving pregnant and parenting women in recovery, Freedom House staff gave us a list of partner organizations in each community. Our research team then conducted 10 interviews with current and recent Freedom House clients to identify other organizations they had engaged with while seeking care or in recovery. Each organization was included in the bounded networks that were used as the study's sampling frame. Table 1 shows each network by sector.

Table 1. Network Composition in Jefferson County and Clay County

	Jefferson County (Urban) N = 25		Clay County (Rural) N = 28	
	No.	%	No.	%
Health care	7	28%	5	18%
Public health	2	8%	4	14%
Social services	16	64%	19	68%

The team used a telephone-assisted network survey to understand cross-sector alignment, informed by measuring interorganizational partnerships in each community. The survey included four to five questions in each construct, guided by the Framework for Aligning Sectors and by the SHERO CAB, and providing insights into interactions and perceptions of shared organizational missions, purpose, data, financing, and governance. The survey also included contextual questions related to operations and partnerships during COVID, presence and use of community-based data sharing systems, and presence and participation in community coalitions.

Freedom House staff helped us identify key contacts at each organization and participated in recruitment for the network survey. Organizational representatives were invited to participate in the survey on behalf of their organizations. All participants scheduled a one-hour phone interview with a study team member to complete the survey; their responses were entered in Qualtrics.[26]

We used social network analysis to examine alignment between health care, public health, and social service organizations addressing substance use and family well-being in each community. The survey responses were analyzed for several key measures to indicate the nature of interorganizational partnerships and the presence of cross-sector alignment around purpose, data sharing, governance, and financing, with a focus on overall within-sector and cross-sector density. *Density* is a network-level measure that indicates the extent to which network organizations are tied together in specific ways. The higher the density, the closer the ties among network organizations. We used all qualitative responses to analyze key themes within and across the two communities.

VOAMID and Freedom House staff were critical community partners, providing insight and context for the network survey findings through biweekly conversations held throughout the study's time frame. Our team also organized and convened a CAB of community members and organizational representatives from both communities. The CAB had active participants from all sectors in both communities and provided meaningful input on interpretation of findings, implications for their work and communities, and opportunities to share the work with local stakeholders.

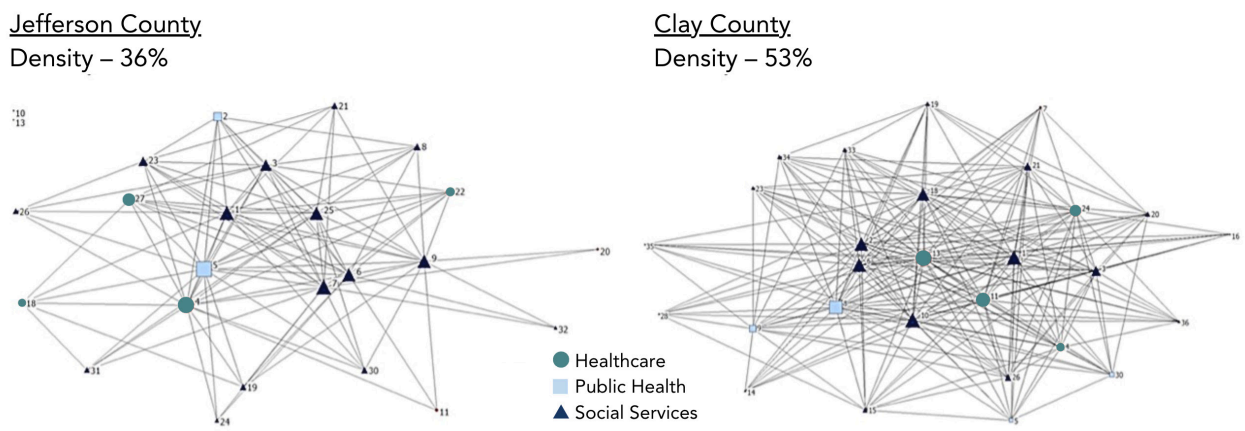
Findings

We did not find substantial differences in overall alignment by community; the density was 41% in Jefferson County (urban) and 44% in Clay County (rural). However, we did observe variations when we examined alignment within the framework's individual constructs. One way in which we operationalized shared purpose was related to organizational perceptions of shared missions across an organization and the other organizations in the network. We observed more mission alignment in Clay County, potentially related to an interconnected and dependent local culture. In contrast, Jefferson County organizations tended to have more individualized missions, possibly because increased competition and overlap in service delivery led to more differentiation in the local market.

The Jefferson County system of care serving pregnant and parenting women in recovery is more aligned in terms of financing and data sharing. The qualitative analysis and CAB input provided context explaining why this may be the case, as these organizations are participants

in local systems established to share data and are resourced in ways that facilitate the formal partnerships required for sharing financing. In contrast, Clay County had more alignment around shared purpose and governance. The CAB indicated this is likely related to a closely connected culture in which organizational leaders and staff meet each other routinely and depend on shared decision-making to meet community needs with fewer financial resources, as well as less technical infrastructure for formal partnership (such as data sharing). Network diagrams are useful in visualizing structural differences in alignment between the two communities. Figure 2's diagrams show the presence of ties around shared organizational missions — which was one way that we operationalized shared purpose — and show the higher density in Clay County.

Figure 2. Network Diagrams: Alignment Around Shared Mission in Jefferson and Clay Counties



Our study's primary focus, of course, was to understand cross-sector alignment and explore differences in it across these rural and urban communities. On average, both communities have 37% cross-sector density, meaning that 35% of all possible cross-sector ties that could be present are actually present. However, when overall cross-sector density is decomposed by subtype, we see substantial variation across the two networks. Rural Clay County had higher cross-sector alignment when the health care sector was engaged; both its health care–public health and health care–social services ties were higher than those in Jefferson County. Alternatively, we observed higher cross-

sector alignment in Jefferson County between public health and social service organizations. The CAB noted two key community characteristics that might explain these differences. First, in Clay County, the local hospital is engaged in several local community activities that incorporate partnerships across multiple organizations, thus explaining the hospital system's central role in the network. Second, in Jefferson County, the local health department had made considerable efforts to establish and strengthen community partnerships in recent years, which is reflected in a strong cross-sector presence involving public health.

Regarding community engagement, our study had several key findings, including identified facilitators and challenges. Facilitators of the SHERO study's community engagement approach included a strong partnership during grant writing. Members of the VOAMID and Freedom House leadership teams participated in conceptualizing and writing the original grant proposal, as well as in strategizing on how to adapt to the global pandemic's circumstances once the project was funded. The entire SHERO team was committed to shared decision-making, meeting weekly, and celebrating study-related and professional successes together. Recent graduates of Freedom House were engaged both as members of the study team and as participants. Our grant facilitated our hiring a community coordinator, who was also a Freedom House graduate. The coordinator participated in the SHERO study throughout the project period, leading to a full-time position at VOAMID. Nearly every Freedom House graduate we spoke with wanted to participate so that they could help other moms and families.

Community engagement was not without its challenges. These included early personnel turnover in the community coordinator position, which required adapting our team training approach to balance lived experience with skill development in new roles. It also took longer than expected to onboard each community member with research and human-subjects training and to formally add external study team members for institutional review board review and approval.

Discussion

The SHERO study demonstrates rural and urban differences in alignment among community systems of care in Kentucky. Other studies also demonstrate rural and urban variations in delivery, use, and structure of substance use treatment interventions.[27,28,29] However, our study is the first

to focus on systems of care and cross-sector alignment in the context of community substance use treatment and family supports. Our findings indicate that both communities have their own strengths and challenges, and public or philanthropic resources may need to adapt in order to leverage such strengths and target improvements at a local level.

The SHERO study generated considerable interest at the local, state, and national levels. In total, our findings were presented to the CAB at least four times throughout the project, as well as to VOAMID leadership, including the executive team, board of directors, and regional advisory councils; to the community, as part of a roundtable discussion with state and national elected officials and agency leaders; and at three state and national professional academic conferences. We also have three papers under review at peer-reviewed journals.

Beyond contributing to the cross-sector alignment literature, the SHERO study also informed practice at VOAMID, Freedom House, and other local organizations. From the VOAMID perspective, the study's key outcomes include the need for a focused effort to strengthen internal structures and systems that promote successful research partnerships, including robust data systems that allow evaluation of program outcomes. To build meaningful community research partnerships, research institutions and universities should streamline onboarding processes for community partners to fully leverage the opportunities that community-engaged research brings to changing policies and practices. Finally, in terms of academic partnerships, the SHERO study found evidence of both successes and failures, as well as a demonstrated need for quality improvement and program adaptations that facilitate meaningful, evidence-informed program improvement. Key to this was gaining insight into how VOAMID can establish stronger links with current and potential partner organizations and do so with a better understanding of the community dynamics that influence interorganizational relationships and service delivery.

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Meaningful Community Engagement: Going Beyond the Box Checking

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For cross-sector alignment and community change initiatives to succeed and be sustainable, the public health, social service, and health care sectors must engage with the communities being served and the people who have actually experienced the targeted inequities. Partnering with community members with lived experience enhances the community's ability to address its own health needs and health inequities, which is the ultimate goal.[1] However, time and time again, engaging with communities in a meaningful, effective way proves challenging, and it often results in organizations finding ways to "check the box" or only superficially engage with community members. To explore this critical issue in cross-sector alignment, the Center for Community Health Alignment at the University of South Carolina Arnold School of Public Health and other collaborators engaged in a two-year project in partnership with state and community-level leaders and residents in four communities.

Here, we describe the challenges we found, community perspectives on those challenges, and — most crucially — the strategies that emerged to address these challenges in ways that respect and engage community members and more successfully meet their needs.

Community Health Workers as Process Leaders

For our research to authentically reflect community engagement principles, two things were imperative. First, our team had to comprise both experienced researchers and trusted individuals who have worked at the community level. Second, the power and decision-making had to be equitably shared across all members of our research team. To meet these goals, three of the five leadership team members who designed the initial project proposal were community health workers (CHWs).[2] Once we received funding, we contracted with four additional CHWs to be core leaders of the research team and trained them in research methods.

CHWs advocate for and support the increased capacity of the communities in which they work.[3] Having CHWs involved in participatory research projects not only allows for representation of their community's views on important health issues, it also creates awareness amongst the research team of the many challenges faced by communities experiencing inequities, while maintaining a strengths-based approach.[4] The CHWs on our research team equitably shared responsibility for developing all research tools, drafting all discussion guides, creating recruitment

materials, facilitating community conversations, and analyzing data.

This approach resulted in the ability to more effectively engage community residents in the research process. As trusted individuals in their communities, CHWs have knowledge and relationships that significantly helped with recruitment and project participation. Additionally, because community members trusted the CHWs, they trusted the project — including the academic researchers and collaborating organizations at the table. Furthermore, the CHWs were able to effectively communicate the community's needs, concerns, and priorities to the rest of the research team, which helped to inform the research questions and next steps. Finally, because the CHWs had established relationships in their communities, project participants felt comfortable in openly and honestly sharing with our team their thoughts about their community and what it needs to move forward. In this way, the CHWs not only expanded the reach of the work but also gave it deeper meaning and impact.

Community Engagement: Challenges, Findings, and Strategies

The components of the research project included multiple sets of interviews and a series of dialogue sessions in four communities across the state. We conducted two iterations of community dialogue sessions — called *open mic discussions* by CHWs and the local partners — in each of the four communities. We held the sessions in a diverse range of neighborhoods and recruited individuals from different demographic groups to ensure a range of perspectives. Our project produced volumes of actionable, community-generated information; in the following, we focus on some of the community engagement challenges that emerged. We also highlight strategies to address these challenges that offer guidance for working alongside communities in a more meaningful and sustainable way.

Challenge: Building Relationships and Trust

Trust and relationship building emerged as central themes in our research, yet organizations rarely give these elements enough intentional work and focus. People coming into communities

may not know how to approach or connect with community members; they may think they are building trust, but it may be ineffective or perceived as insincere by community members. One statewide leader with experience in community-engaged work noted that while organizations may like the concept of community engagement, the reality of what that looks like is sometimes abstract at best:

> **The idea of having those people at the table, it's just foreign to them. … 'I want to hear what you have to say about it, but [the idea of] having a leader of your group or whatever actually sitting at my table …' I don't think that they think it that far.**

Strategy: Prolonged Interactions

Building trust requires time: taking the time to listen, to see things from other people's perspectives, and to make genuine connections. Investing this time helps team members to get to know people in a community on a deeper level through prolonged interactions, as well as to gain respect and empathy for their needs. To build effective relationships that facilitate engagement, it is important for team members to continue to show up, to ask how they can be more involved in community activities, and to build trust through action and patience over time.

Strategy: Partner With Gatekeepers

Trust is built through consistency, commitment, honesty, and follow-through, and oftentimes community gatekeepers or champions can facilitate these critical components of trust. A statewide interviewee said that connecting with local people can be challenging without gatekeepers; in such cases, organizations —

> **lack someone who has that front-row, face-to-face contact with the most vulnerable in their communities, [someone] who's able to speak with them on their experience to give the different perspective of what people are experiencing in the community at large.**

Another interview participant explained how genuine dialogue with community gatekeepers is important to creating a relationship, including by —

> **finding out who those influencers are, building transparent and honest relationships with them — not overpromising and underdelivering — but just being honest with them about what you can do and what you can't do.**

Challenge: Histories of Broken Promises

Communities may be hesitant to engage in efforts because of prior experiences of disingenuous engagement that failed to produce meaningful change or that produced only short-lived change. Many open mic participants shared stories of broken promises from local policymakers, developers, and human service organizations; such experiences resulted in an overwhelming lack of trust in not only the individuals responsible, but also other people from those sectors. One person at an open mic session explained why their community lacked interest in the whole process:

> **[They] want us to come out and vote or come to their meetings and things like that. It's like, once they're where they need to be, they disappear. And the thing is, they'll come out, they'll shake your hand. 'You need anything? I got somebody in my building, I got somebody in my office that works with that.' You reach out and get their email addresses and email them, and they don't even contact you back. They don't even contact you back.**

Participants also said that efforts to engage the community sometimes appear selective and solely at the convenience of outsiders. Community members view these selective engagement opportunities as inauthentic or disingenuous — as based on the organization's need, rather than the needs of the community. As one interviewee explained,

> **No one disengages faster … and [we] never hear back … until two years later and it's time for you to do another listening session for your grant deliverable.**

Strategy: Follow Up and Follow Through

Community leaders discussed the importance of following up after collecting information or ideas from community members. For example, our project hosted community data sharing sessions to inform the community of what we learned in the open mic discussions. In discussing plans for the follow-up sessions, one of the team's CHWs shared the following:

> **[We should] go back to the communities … and invite a larger audience, including policymakers and key players, so that we can work alongside residents to bring about the change they want to see and get the word out about their concerns … and develop tools and best practices to have for people who want to engage in this work.**

Challenge: Acknowledging and Understanding Local Context

A major theme in the open mic sessions was how outsiders — both people and organizations — come into communities and deploy events and programming that do not match with a given community's actual needs. Participants shared that violence in communities and the effects of it are currently at the forefront of many people's minds. Other significant concerns are a lack of affordable housing, economic development, and other key resources — including education, childcare, transportation, and jobs.

As one open mic participant explained, however, when institutions focus on their own priorities instead of what the community actually needs, apathy and frustration may result:

> **We get tired of doing stuff because somebody else from the outside has an idea, but then … we go and then the community doesn't show up, and then everybody says, 'Well, the community didn't show up.' Well, that's because that's not what the community really wanted. So, I think it's kind of just getting to know and meet people.**

Another salient theme we found was that, while well-meaning, outside groups often fail to build a true partnership because they don't understand the local culture and history. A statewide leader of community engagement explained this as follows:

> **It's mostly how the message is being brought to [people] with lived experience. You've got to understand, there's culture there. If I want someone to change how they eat, well you have to realize they've been eating like this since grandmamma's, grandmamma's grandmamma. … knowing how to actually sit down and have that conversation with the individual and recognizing the culture.**

Equally important, if groups are not willing to hold difficult conversations that acknowledge racism and its effects, generating authentic relationships is likely to be challenging at best. Two communities that participated in open mic sessions mentioned major events in their communities' history that continue to shape residents' perspectives — and their feelings of mistrust and being ignored. It is only by talking openly about these events, they said, as well as the historical, structural racism that has impacted their communities, that effective relationships can be built.[5,6] As one resident stated, "That's the elephant in the room that nobody likes to deal with."

Strategy: Discuss Local Context, Culture, and Key Historical Events

Effective community engagement requires learning the local culture and context related to the target topics. It also means having difficult conversations, which may include acknowledging how the community has been mistreated and discussing issues relating to racism and inequitable opportunities. It is important for people coming into a community to listen to the communities' concerns, acknowledge them, and be up front about whether those priorities can be addressed within the initiative's scope. It is also critical that the community be given the opportunity to decline to participate — or, if possible, to reshape the initiative's focus on their own priorities. If such a reshaping is not possible, consider offering to connect the communities with other institutions that can help address their concerns.

Challenge: A History of Imposed Decision-Making and Governance

Outsiders often come into neighborhoods and make decisions *for* the communities instead of *with* communities. This leaves residents outside the decision-making process and results in their disenfranchisement. One community resident who participated in open mic sessions explained community disenfranchisement as follows:

> **It seems to play out where somebody tell you, 'This is what we going to do. Whether you like it, don't like it.' A lot of time people just come, especially [when] you talking about people with clout and power. Sometimes they'll pacify you and listen — or pretend they're listening — but they already have their mind made up.**

Strategy: Share Power During All Project Phases

Community leaders said that it is essential to include community members in every phase of any community initiative; this, historically, has not always been the reality. One community leader explained it as follows:

> **I think we missed the mark a lot of times. We just get a lot of great ideas, but by the time they get to the community, the community is just kind of like, 'Where did this come from? Who said that we needed this? Who said that this is the right way to engage with us?' I think inviting the community in or some type of folks who represent the community when that work is being identified, when that work is being thought of, when those partners come in that room to decide how they're going to divvy out the funding for specific projects … especially those folks even on the grassroots level, getting them in on the front end and helping them understand the process behind why decisions are made — I think that is very important..**

Community members should be invited to contribute to initiatives in different ways. For example, community members could be asked for their opinions or given a role in decision-making processes. Or they could be asked to share knowledge and information about their community. Engaging community members in active roles might include having them act as formal and informal advisers, serve as intermediaries with the community, provide historical context, be outspoken champions of causes, and participate in and volunteer at events. Also, as one CHW research team member emphasized, community members who are involved in efforts should be paid while they work alongside organizations' members.

Strategy: Use Various Approaches to Communicating With Residents

Multiple communication strategies are needed to reach community residents and let them know how they can be involved, including in-person promotion in neighborhoods. One community resident explained the need to take information to community members in their natural meeting places:

> **We got to go to the barber and beauty shops. We just can't rely on Facebook and Instagram and those other things, which is what seems to be what's popular now with communication. I think we've got to look at different ways of communicating so that the people that need the message can actually get the message.**

When events are held in communities, organization members should make efforts to talk to residents rather than talking only to their own colleagues or team members:

> **So, you have to branch out your comfort zone … branch out when you go in communities and start talking to somebody new that you don't know. Because that's the only way that you're going to get people engaged, by going up to them, talk to them, visiting them, and different things. And I didn't see much of that out [of] the organizations that came here; they basically just talked**

> **amongst one another. Some of them did, but the majority of them didn't; they didn't take time and say, 'Hey. How are you doing? How's life been treating you?' or 'What's going on?' They didn't engage in that, so you can't expect for the people in the community to engage.**

Challenge: Creating Accessible, Respectful Engagement Initiative

Coalition or community meetings are often held during the day or just after work, which can make it difficult for people to participate. Other challenges to reaching community members include using common terms rather than jargon, and understanding that residents might lack transportation, cellphones, or computers and internet access.

One statewide community engagement leader explained the need for accessible meetings and events as follows:

> **A lot of people travel out of their county to go to work. So, they're not available during the day … and a lot of coalitions meet over lunch or they meet during work hours. So, some of the people who actually live there are just simply not available during the day.**

In relation to organization staff using jargon at meetings, one community leader illustrated the problem from personal experience:

> **When I heard 'food desert' for the first time, I had no idea what that meant. I asked several groups, and they didn't know. People still don't know that [it] means there's no grocery store.**

Another state stakeholder noted that using jargon and technical terms can also discourage community members from participating and that meeting formats may need to be revised to connect with the people with whom we want to engage.

Strategy: Meet People Where They Are

To authentically and respectfully engage with communities, sector leaders must be flexible and creative and engage with people in different ways. A community resident explained this need:

> **You have to meet people where they are … and it might not necessarily be that professional setting. And … sit down and listen and not just discredit them because they're not as articulate or hadn't been to school for 30 years. If they have something to say, you should listen, not brush them off as they're not educated.**

The timing and location of meetings and events should be key considerations. Some participants suggested working through trusted organizations that are already gathering places — such as churches, schools, food banks, fraternities and sororities, neighborhood associations, and organizations with CHWs — and holding meetings at these places at times when people normally gather.

Messaging is also important, including the ways in which messages are developed and delivered. When working to create new connections, both the message and messaging should be crafted with care to ensure that they resonate with community members. Again, it is important to avoid technical language and research jargon, which is off-putting — and suggests that you are working "on" communities rather than "with" them.

Challenge: Some Funding Structures May Inhibit Authentic Engagement and Collaboration

Participants cited two key barriers to community engagement related to traditional grant funding. First, they said that grant-funded programs often lack sufficient time for planning and initial relationship building. Second, as mentioned before, grant funding opportunities often arrive in communities with preset agendas that are unaligned with the community's needs, interests, or prior traumas. For example, a community may be concerned about safe and affordable housing or

violence, but the program or initiative focuses on increasing fruit and vegetable consumption.

One person explained how these issues can inhibit authentic engagement and collaboration with community members:

> **I think one, is that it's hard to do [community-engaged work] well when you have a project you need to accomplish. So, when you go to a community and you say, 'Help us understand what you need as a community,' and they say, 'We need our streetlights fixed,' and you are actually there to do reading education and support for the kids in the neighborhood, are you going to fix the lights? Because that's not what you do — that's not what you're funded to do. … So I think there's barriers because there's not funding for — generally, there's not a lot of funding support for just listening to your neighborhoods and identifying their needs — and meeting them — regardless of what they are and whether or not they fit into the box that you want them to.**

Strategy: Redesign Funding Opportunities

Ideally, funders would require or invest in an initial planning phase that goes beyond the traditional 90-day period; in reality, it may take up to a year to build relationships and fully understand community context, needs, and strengths to build on. Funding or program development opportunities should start with the communities, and community leaders should be part of conversations around priority-setting and resource allocation. If a grant funding opportunity does not align with a community's priorities, the funder should be open to changing its priorities or finding a creative way to include resources that address the community's actual concerns.

Challenge: Increasing Capacity Building in Community Engagement Techniques

Research participants suggested the need for more capacity building around community engagement. One state-level leader described the challenges as follows:

> **So, we talk about, all the time, evidence-based programs; well what is evidence-based community engagement? We need to create a model — or identify effective models — and then, in future grants, support a wider use of those models..**

Strategy: Increase Authentic Engagement Capacity

One way to leverage funding toward meaningful community engagement is to build capacity and tools to help organizations and communities partner in a more equitable way. This could include guidelines for how to work together and how to reach out to the people most affected. Other capacity-building suggestions that we heard included training community members on how to engage on their own terms and build more shared power; training for multisector coalitions of organizational leaders, alongside local community groups, to facilitate opportunities to learn about each other's context, culture, and priorities; and capacity-building efforts to assist communities in building connections with larger, statewide efforts.

Conclusions

While multisector coalitions, public health providers, health care providers, social service providers, researchers, and funders all understand what community engagement entails, it still proves difficult to authentically engage with the people most impacted by health inequities in a meaningful way. Our project gathered a wealth of data to inform this persistent challenge. Across our data, similar themes emerged that point to a clear set of challenges to community engagement, as well as to strategies to help address the challenges. Critical themes included the importance of trust and relationship building, meeting people where they are, respecting local culture and history, being open to difficult but necessary conversations, and being intentional and flexible around how to involve community members in all parts of the process. Further, we found that funding structures need to facilitate community engagement and long-term investment, provide ample time for requisite relationship building, and allow for the agenda to emerge from community members over

time. Participants also identified the need for training in best practices for community engagement and for additional capacity-building support for institutions, community coalitions, and other community leaders. Implementing these community-generated solutions to promote community engagement will enhance the ability of practitioners in multisector alignment initiatives to create lasting partnerships for collective impact.

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Indigenous Healing and Health Systems: Revitalizing Inherent Alignment

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Over the past 20 years, American Indian and Alaska Native health services research has grown substantially,[1,2] yet few studies examine the alignment between tribal health, public health, behavioral health, and social services systems.[3,4,5,6,7,8] American Indian and Alaska Native health systems face many challenges, including (1) limited capacity and skills to serve key population groups, (2) limited interoperability of various health and support systems, and (3) a lack of reliable data.[9,10,11,12,13] Although non-native providers and systems generally understand neither the need for nor the benefits of collaborating with tribal systems, new research suggests that both health systems gain when such collaborations occur,[14] and some regions are now working closely with local tribes to improve data reliability.[15,16,17] Such cross-system alignment can introduce efficiencies in service delivery, ensure care quality, support holistic approaches that provide wraparound services, and offer population-level and system-level indicators to best assess and ensure community and population health and well-being.[18,19]

Tribes and urban indigenous health organizations have made tribal system alignment an ongoing priority, but such efforts have yet to be assessed or described in peer-reviewed journals. The Indian Health Service and Tribal Health/Urban Indian health systems represent significant diversity in the services delivered, populations served, and availability of resources,[20] making research across multiple health systems challenging. Moreover, researchers and public health practitioners often ignore or misunderstand the cross-sector connection with indigenous knowledge systems, approaches to wellness, and connections to community, land, and culture.[21,22] Finally, despite treaty rights guaranteeing health and other U.S. government services, the limited resources available to tribal communities require creative solutions to overcome limitations and support American Indian and Alaska Native community health (see, for example, work by Haroz and colleagues).[23] Here, we describe an exploratory study of system alignment efforts within four American Indian tribal health, public health, social service, and other tribal departments and provide some early results from this study.

Exploratory Study of Tribal Systems Alignment

As part of the Georgia Health Policy Center (GHPC) Aligning Systems for Health initiative, a team of researchers from the University of Washington's Seven Directions tribal public health

institute explored the key components of tribal system alignment among four tribal partners as part of a collaboration with Red Star International, a nonprofit partner focused on indigenous health, and an advisory board familiar with American Indian and Alaska Native health and behavioral health systems. The Indigenous Healing and Health Systems: Revitalizing Inherent Alignment study had three primary aims: (1) engage tribal stakeholders in a practice-based study to describe existing tribal system alignment, (2) support each tribal transformation team's cross-sector system alignment project by providing funding and capacity assistance, and (3) describe an emerging framework for cross-sector alignment within tribal nation systems.

Study Approach and Methods

Our study used a practice-based approach focused on formative work in the community and the use of partnership models such as community-based participatory research.[24] Community-based participatory research is a set of principles that guided the research partnerships (i.e., tribal stakeholders and research/capacity assistance team) throughout the study to ensure equity, empowerment, and support of community capacity development.[25] The study followed all tribal research and review processes and obtained University of Washington Institutional Review Board approval prior to launching.

Funded at the beginning of the COVID-19 global pandemic — which disproportionately impacted tribal communities[26] — the project could not be a major priority when tribal teams were facing significant health concerns coupled with the need to rapidly adjust in real time to issues such as provider and patient flow, service provision, vaccine administration, and staff shortages. Our study team therefore revised our original research and technical assistance plans to honor participants' needs and respect the priorities of the participating tribal communities. Our partners at Red Star provided support to develop the alignment plans, along with funding for implementation. Red Star also met with each team regularly for online check-ins and worked with tribal teams to develop a success story that documented their efforts over the one-year project. We invited the tribal team members to participate in interviews and surveys (described below) with the understanding that their projects were nested in a research study exploring important tribal system alignment factors. With advisory board and Red Star input, we developed two sets of surveys and interviews

that addressed constructs from the Framework for Aligning Sectors and asked participants about barriers to and facilitators for tribal system alignment. We collected primary data at baseline (T1) and at the end of the grant (T2) and conducted interviews April–June 2021 (T1) and February–April 2022 (T2). We conducted the surveys August–November 2021 (T1) and April–June 2022 (T2). To protect participant privacy and confidentiality, we generated random numbers for the study IDs. We recruited tribal team members through letters of invitation that included consent forms and an offer of a $25 gift card as compensation for their time. We interviewed consenting participants via phone or online in 90-minute semistructured interviews; we recorded these sessions with permission and had them transcribed by a professional transcription service. After verifying the transcripts, our team engaged in data analysis, akin to phenomenology, using deductive and inductive analysis. We used a codebook with a *priori* codes, checked intercoder agreement, and identified and agreed on reoccurring ideas or themes. Participants completed the survey online using an individualized link. We developed the survey questions, including a few that we adapted from alignment and related studies. All survey questions were programmed into Research Electronic Data Capture (REDCap) version 12.3.3, and we did the analyses in RStudio (R versions 4.1.1–4.2.1). Because our total sample size was low, our analyses are limited to univariate descriptions of frequency and means.

Results

Approximately half of the survey participants identified as American Indian or Alaska Native at both T1 and T2. Participants were employed by the tribe or tribal organization for an average of nine years (T1 and T2); as Table 1 shows, the time in their present position (six to seven years) coincides with their years at the organization, minus two to three years.

Table 1. Characteristics of Survey Population (T1 and T2)

	T1 (*N*=19)	T2 (*N*=22)
Race		
American Indian/Alaska Native	10 (55.6%)*	12 (54.5%)
		μ (sd)
Avg. years employed by tribe	8.6 (6.8)	8.8 (8.0)
		μ (sd)
Avg. years in current position	6.7 (6.7)*	5.6 (5.9)
*n = 18		

Tribal system alignment team members represented several tribal departments, including tribal health, public health, social services, health/behavioral health, education, and judicial services. Among the government leaders who participated in the system alignment work, the most common were chiefs, chairpersons, and governors. We now describe our findings for the adaptive factors and structural components of alignment, as well as how tribal teams perceived their relationship to those factors and components in the framework.

Adaptive Factors: Accountability vs. Community Voice

The following items from our survey demonstrate tribal team members' perceptions of their role in supporting health and well-being within the tribal community. Across the four tribal communities, tribal system alignment team members confirmed a strong sense of responsibility for supporting their communities; this sense was consistent at the beginning and end of the project. About 94% of participants at the beginning and the end of the project indicated that they often or always felt a sense of responsibility to work in service to their tribal community. Table 2's heat map shows the frequency of responses to these survey items by response category.

Table 2. Heat Map of Survey Frequencies for Relational Accountability (T1 and T2)

We have a responsibility to work in service to our tribal community(ies).

Time	Never	Rarely	Sometimes	Often	Always
Time 1 (n=18)	0	0	1	5	12
Time 2 (n=22)	0	0	1	3	18

Our T3 team integrates social and cultural ways of being well that are important to our tribal community(ies).

Time	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
Time 1 (n=18)	0	0	3	10	5
Time 2 (n=22)	0	1	3	12	6

Our T3 team regularly shares data and progress reports with tribal partners, community and leadership.

Time	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
Time 1 (n=18)	1	1	5	9	2
Time 2 (n=22)	0	3	5	13	1

Team members also confirmed that the integration of social and cultural perspectives of wellness was important to their tribal community. Agreement or strong agreement with this remained consistent at the beginning (83%) and end (82%). More than half of participants (61%) during T1 indicated that their team regularly shared data and progress with tribal members and leaders; this increased to 64% during T2. In our individual tribal system alignment team member

interviews, participants expanded on these tribal adaptive factors, confirming the "accountability to community" concept as an adaptive factor. Exemplar quotes representing this concept were coded under positionality, community, and trust relationships. One interviewee, a manager, shared the following, which exemplified how many people connected their accountability to their own role and the community at large: "This is where my parents live and where my children are being raised. … If I want things to get better here, I gotta be part of that change."

Structural Component Governance: Collaboratives and Tribal Sovereignty

Landers and colleagues define governance as "the organizations involved to maintain robust governance and leadership structures that include and elevate local representation and voices" (S119). Table 3 shows results for two tribal survey items that fall within this definition: (1) working within a defined approach and (2) developing and entering into formal agreements that confirm alignment policies and practices. At T1, 72% of participants agreed or strongly agreed that their team was guided by a specific approach to achieve tribal system alignment.

Table 3. Heat Map of Survey Frequencies for Governance Items

We have an approach that guides our alignment project.

Time	Don't Know	Strongly Disagree	Disagree	Neutral	Agree	Atrongly Agree
Time 1 (n=18)	1	0	0	4	11	2
Time 2 (n=22)	2	1	3	1	14	1

We will enter into formal written agreements for this project (e.g., MOU/MOA, IGA, Interdepartmental).

Time	Don't Know	Strongly Disagree	Disagree	Neutral	Agree	Atrongly Agree
Time 1 (n=18)	0	1	0	4	11	2
Time 2 (n=22)	5	1	0	7	9	0

All four tribal partners planned to establish formal agreements with internal and external partners. While 72% agreed or strongly agreed at T1, fewer participants confirmed a plan to establish formal agreements at T2. This may reflect a change in each team's makeup and the degree to which they were aware of efforts to establish formal agreements at the end of the study. The teams were made up of upper and middle management but also program managers and contractors. Therefore, their awareness of formal agreements being put into place would vary. Additionally, the respondents change from T1 to T2, and this would also impact their awareness. The individual interviews provided a more nuanced understanding of governance within and across alignment teams. The theme of tribal governance emerged from respondents talking about it as a structural core component, based on trust relationships, and contextualized by tribal sovereignty. Themes of customary ways of governing and engaging with the community (i.e., through relationality and accountability) emerged from the co-occurrence of these codes. The following interview quote (from an administrator) encapsulates this practice of tribal governance:

> **Community health assessment helps us look at those types of missing data from different departments. Especially for talking about social determinants … where is the data that helps connect? You need to find out what is that data and how can we get that data to get to make it a full picture of [name of tribe].**

Community health assessments are one way to identify such gaps in the existing data system. Performing the functions of public health (i.e., assessment, assurance, and program/policy development) highlighted the gaps and contributed to the development of and linkages to data systems for indigenous data sovereignty and governance.

Table 4. Heat Map of Survey Frequencies for Tribal Data Systems Items

The goal of our Tribe/Tribal entity is to have a data system that can exchange data across programs and services (interoperability).

Time	Strongly Disagree	Disagree	Neutral	Agree	Atrongly Agree
Time 2 (n=22)	0	1	3	7	11

Our Tribe(s) feels confident in their ability to maintain the data system.

Time	Strongly Disagree	Disagree	Neutral	Agree	Atrongly Agree
Time 2 (n=22)	1	1	7	11	2

Discussion

As we now discuss, the results of this exploratory study indicate that tribal system alignment teams have unique understandings of the adaptive factors and core components needed to support system alignment, and some of these factors may be specific to tribal system alignment. Our study also has a few limitations, largely related to its size.

System-Specific Components

We found three distinct components of tribal system alignment: accountability to community, tribal governance, and tribal data system development "by and for" sovereign tribal nations. The *accountability* to *community* factor ensures that system alignment efforts are attuned to the framework's four adaptive factors (i.e., community voices, equity, power dynamics, and trust). Underlying this accountability factor is a subtheme of relational accountability among tribal and nonindigenous team members that grounds and informs a culture of alignment. Relational accountability is understood as the collective values and principles that guide an individual's

thoughts and actions when in community (i.e., context and relational).[28] As participants described it, relational accountability is reflected in their positionality, shared purpose that reflects a holistic understanding of community health and well-being, and their relationship to their community and their tribe. Relational accountability also informs how leaders lead, both within the alignment teams and across their tribes.

Tribal governance is the second distinct component for tribal system alignment. Governance plays a central role in the context of tribal sovereignty. Practicing cross-sector governance may include strategies among organizations that either prioritize institutionalization (i.e., formalized agreements) or the definition of team roles (i.e., leadership), but few strike a balance between the two.[29] In contrast, responses by our study's participants indicate there must be a balance here for long-term collaboration. Participants from the four team sites shared the importance of agreements, reporting to tribal oversight committees, and their leaders' customary/cultural responsiveness. In the United States, Public Law 93-638 authorizes the federal government to contract directly with tribal nations, respecting their innate cultural and political sovereignty over the development and operation of their tribal systems.[20,30] Tribal leaders (e.g., chairpersons, chiefs) are elected by the tribal community to carry out their customary responsibilities for the health, welfare, and safety of their communities. These leaders, in turn, appoint leadership for various sectors — that is, such sectors are not independent organizations with leaders hired by their governing boards. This arrangement requires a balance of institutionalization, roles, and relationships that ensures communication, transparency, and trust.

The final distinctive component for tribal system alignment is *tribal data system development*. While the most participants reported that having a data system aligned across tribal departments was their goal, fewer indicated that they believed it could be maintained. This speaks to a need for cross-training to understand the interoperability of data systems within tribal alignment teams. The fact that the teams are strengthening their data systems by developing interoperable systems is an exercise of *indigenous data sovereignty* — which refers to the right to control and steward data as knowledge from creation to management within the tribal system. Having well-established data systems with capacity, infrastructure, and control and ownership secured, and working within the indigenous data sovereignty principles, will provide data for governance.[31]

Limitations

Our study's limitations include the small number of tribes participating, as well as a small number of individual participants (i.e., four to six team members per tribe). Further, the composition of individual participants from each of the participating tribes changed over the study period. Such changes in team composition did not allow for descriptive comparisons within or across teams over time. Finally, initiating this study during a pandemic caused delays both in launching and continuing individual alignment projects and in participation in the study activities. Despite this limitation, more than 50% of the total number of individuals from the four tribal alignment teams participated in the interviews, completed the survey, and attended the all-team meetings at the beginning (T1) and end (T2) of the study.

Conclusion

We conducted an exploratory study of system alignment with respect to the framework. Our tribal partners have their own government systems, history of funding, relationships, and long-term aspirations for system alignment. They nonetheless shared three distinct components for tribal system alignment: accountability to community, tribal governance, and tribal data system development. These components were observed by the T3 teams prior to and during the pandemic. In their responses to the pandemic, tribal systems drew on indigenous epistemologies and ways of being in community to increase communication and coordination that went beyond the health, public health, and social service sectors. These seeds of tribewide, long-term collaboration or system alignment have emerged, sprouted, and will continue to grow and strengthen.

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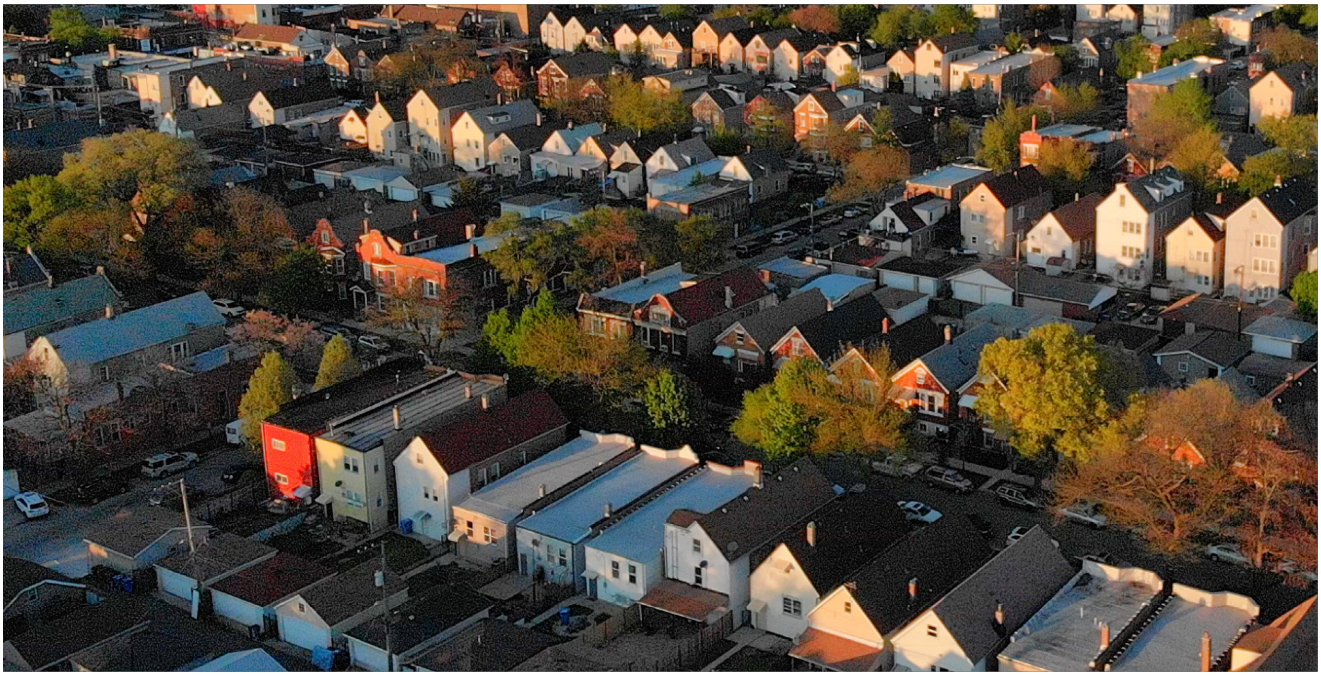
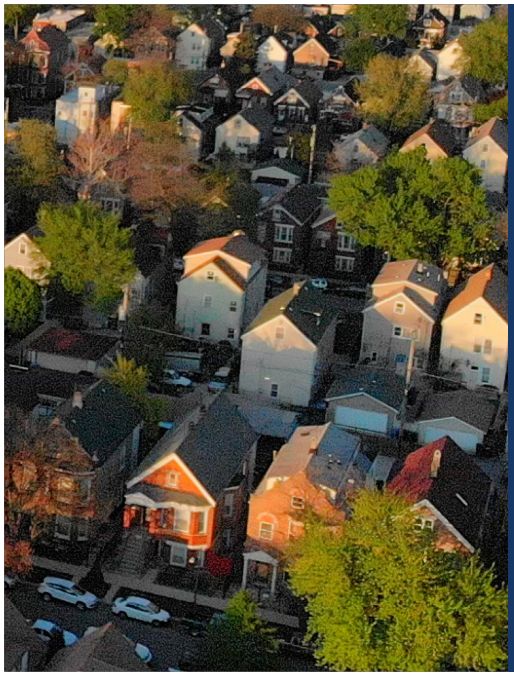
Improving Health and Targeting Inequities on Chicago's West Side: A Cross-Sector, Place-Specific Approach





West Side United

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In Chicago, decades of discriminatory practices, including redlining, blockbusting, and bias in employment and government services, have systemized segregation and extraction of wealth and resources from primarily majority Black/African American and Hispanic/Latino neighborhoods.[1,2] This unjust legacy has resulted in one of the greatest health crises in the country. As of 2020, people in neighborhoods on Chicago's West Side had a life expectancy as low as 66 years, compared to 80 years in the area north of downtown and 75 years across Chicago as a whole (Chicago Department of Public Health, 2020).[3]

West Side United (WSU), a health equity collaborative of six hospitals, aims to use a cross-sector, place-based strategy to reduce the life expectancy gaps between Chicago's downtown and its 10 West Side neighborhoods: West Town, Near West Side, Lower West Side, East Garfield Park, West Garfield Park, North Lawndale, South Lawndale, Humboldt Park, Belmont Cragin, and Austin. WSU also aims to improve neighborhood health by addressing inequities in health care, education, economic vitality, and the physical environment. In addition to the six hospitals, WSU partners span health care, public health, and social service organizations and include community organizations, residents, local churches, small businesses, and large private-sector businesses. WSU partners work together to coordinate investments and interventions and share outcomes, and believe in the impact of cross-sector partnerships and initiatives. The Framework for Aligning Sectors enabled us to explore the nuances of our alignment (Landers et al., 2020).[4] Specifically, we focused on the framework's four core components: a unifying purpose, shared data to assess progress, sustainable financing, and governance structures that include community voice.

Research Aims

Our project aimed to identify and evaluate WSU's purpose, data and measurement system, financial sustainability plan, and governance structure in relation to effectiveness, the utility of development tools, and whether they facilitated cross-sector alignment. We also sought to understand how well we incorporated community voice into each component and how community engagement shaped WSU activities.

Methods

We used a mixed-methods approach that included document review, key informant interviews (KIIs), a survey, and insights from a community sense-making session to triangulate data and answer our research questions (see Table 1). All activities were approved by Rush University Medical Center's Institutional Review Board (20061505-IRB01).

Table 1. Research Aims, Questions, and Methods

Aim	Research Questions	Method
Aim 1: Understand the best mechanisms (tools and processes) for alignment within each of the framework's four components.	What tools have we used to develop each of the four components (purpose, data, financing, governance)?	DR, KII
	Do WSU stakeholders/partners find the tools useful?	Survey
	Were the tools effective in achieving cross-sector alignment within each of the four components?	Survey, KII
Aim 2: Understand how community leaders and West Side residents were effectively engaged in the development of the four components.	How have we engaged community in the four components?	KII
	Were these efforts effective?	Survey, SS
	How were WSU actions within each component and across domains/initiatives shaped through community engagement across the collaboration?	KII

DR: Document review, KII: Key informant interview, SS: Sense-making session

We convened a community research advisory team comprising five members of WSU's Community Advisory Council. These individuals live or work in our priority neighborhoods and have lived experience in WSU's focus areas. The advisers reviewed and provided feedback on the research plan, KII protocol, survey tools, sense-making session, and deliverables.

Document Review

We conducted a document review including bylaws, minutes, logic models, budgets, memoranda of understanding (MOUs), reports, presentations, external communications, and other organizational agreements to understand how various materials were used as tools to develop alignment. We defined a tool as "a process or product that can be replicated in external collaboratives that attempts to facilitate collaboration and effectiveness within model components." We differentiated tools by categories (e.g., agendas, agreements, presentations), subtypes (e.g., charts, frameworks, maps), and components. We analyzed 229 documents created from January 2016 to January 2021 and identified 1,094 tools.

Key Informant Interviews

We conducted semistructured KIIs with 25 WSU partners, including staff, Executive Leadership Committee members, WSU hospital leaders, and external consultants, as well as with 12 community members and partner organization staff members. We created flexible question banks tailored to each interviewee; our focus was on engagement with WSU, the development of WSU's four components, alignment across the anchor institutions, the tools used to facilitate alignment, and community engagement in developing each component. We conducted interviews via Zoom, and each lasted 45–60 minutes. We developed a preliminary code structure based on the framework and added codes as they emerged in the coding process. Initially, two team members double-coded the transcripts; once we obtained an inter-rater reliability kappa value above 0.70, these two team members independently coded the remaining transcripts.

Community Engagement Survey

We administered a 127-question online survey to community residents and collaborative leaders to evaluate how effectively WSU engaged the community across the framework components. To develop our survey, we leveraged an 11-principle community engagement assessment tool developed by Goodman and team (2017) and adapted questions about component knowledge and community engagement levels from the Public Health Institute's evaluation of accountable care

organizations (2020).[5,6] We contacted more than 500 residents using attendance sheets from past community activities and administered a shortened version of the survey to leaders by reaching out to those recruited for KIIs. We analyzed the survey results in Stata v15.5. We then hosted a 90-minute, virtual sense-making session wherein we invited all residents contacted about the survey to hear results and provide contextual insights. More than 45 community members participated in the session.

Findings

In the following, we present our findings organized by the key aims of our project, followed by general findings from our resident and leader surveys.

Tools and Mechanisms for Alignment

Aim 1: Understand the best mechanisms for alignment within each of the framework's four components

The document review highlighted a progression of tool utilization over time. Overall, purpose had the greatest number of tools, followed by data and governance; few tools were allocated to finance. We found chronological shifts in component tool use that aligned with key organizational developments (e.g., promoting WSU's mission, organizational formation, establishment of governance bodies, and sharing of data framework). Table 2 shows the number of tools identified for each component by year.

Table 2. Document Review Summary Number of Tools by Component and Year

	Purpose	Data	Governance	Financing
2016	17	5	1	0
2017	92	11	66	1
2018	100	26	28	3
2019	362	158	112	25
2020	310	116	60	16
2021	18	18	0	0
Year unknown	62	24	26	9
Total	961	358	293	54

Interviewees frequently described the usefulness of various meeting bodies — including workgroups, committees, and convenings — as tools for alignment. They also identified key personnel who could drive alignment within components. These included institutional leaders, who hosted initial conversations and proposed agreements between hospitals, and consultants and content experts, who developed the data and financing infrastructures leveraging best practices from the field and other collaborative organizations.

Table 3 outlines tools that were commonly mentioned in the interviews and document review, along with alignment facilitators for each component.

Table 3. Common Tools by Core Component and Data Source

		Interviews	Document Review
Purpose	Tool examples	Multistakeholder meetings Interactive activities Publicly available data Community town halls Strong visuals delivering powerful, effective messages	Maps, tables, and other figures Institutional frameworks Report summaries Multistakeholder presentations
	Alignment facilitators	Inclusive environment to share diverse perspectives Data-driven goal setting Consistent and regular engagement efforts Powerful, convincing narrative Relationships with partners and use of existing networks	
Data	Tool examples	Internal and external meetings to share data, findings, and insights Data publications Emails/newsletters Presentations tailored to different audiences	Data publications Presentations tailored to different audiences Figures, charts, maps, and data tables
	Alignment facilitators	Use of readily available data sources Data-driven culture that uses data to guide decision-making and tell a story Qualitative data that informs conclusions and contextualizes/interprets quantitative data Cross-sector collaborations and data sharing practices Capacity building for nontechnical stakeholders (e.g., program staff, community members, senior leadership)	
Financing	Tool examples	Grant/donation-related agreements Spreadsheets/dashboards Grant development and management processes Finance staff and/or consultants	Presentations tailored to specific audiences Descriptive tables and charts related to programmatic funding
	Alignment facilitators	External support to organize finances Existing philanthropic networks to identify and approach funders Transparency of funding sources and spending across partners (even with a single fiscal sponsor)	

		Interviews	Document Review
Governance	Tool examples	Survey, focus groups, interviews for community input Community listening tours Recruitment outreach activities Application/interview process MOUs, contracts, and other formal agreements	MOUs, contracts, and other formal agreements Figures, frameworks, lists, templates, and descriptive organizational structure tables Presentations, report summaries, meeting notes, and organizational plans
	Alignment facilitators	Community engagement at the forefront of governance practices Governance structures can evolve with the needs and development of the organization Clear roles and responsibilities for members	

Community Engagement

Aim 2: Understand how community leaders and West Side residents were effectively engaged in development of the four components.

We framed our understanding of community engagement across the four components using the International Association for Public Participation's Spectrum of Public Participation (SPP) (2018).[7] The SPP includes five stages of community participation, from *informing* to *empowering*, with each entailing progressively higher levels of participant impact on decision-making. We found that community participation varied across WSU's four components, implementation phases (planning vs. implementation), and strategic initiatives (e.g., health care initiative targeting high blood pressure vs. hospital anchor mission programs such as small-business grant giving). Table 4 shows a high-level summary of the components and phases in relation to the SPP and based on information from our community KIIs, community survey responses, and sense-making session feedback.

Most components and phases fell into one of the first three SPP levels (*inform*, *consult*, or *involve*); only a few reached the early stages of collaborate, and none reached the empower stage. Our analyses comparing resident and leader surveys and KIIs also underlined various perspectives on the effectiveness of community engagement efforts, with leaders giving WSU higher ratings

across all components and phases. These findings led us to question where WSU leadership would like to be situated on the SPP for each component, and it spurred conversations in our sense-making sessions with residents about the extent to which they should be engaged in each component and phase.

Table 4. WSU Level of Community Engagement by SPP Component[a]

	Inform	Consult	Involve	Collaborate	Empower
Description	Provide balanced and objective information in a timely manner	Obtain feedback on analysis, issues, alternatives, and decisions	Work with the public to ensure that concerns and aspirations are considered and understood	Partner with the public in each aspect of the decision-making	Place final decision-making in the hands of the public
Phase and component	Planning finance and data; implementing finance	Implementing data and governance	Planning governance; implementing purpose	Planning purpose	Planning purpose
Examples of engagement	Finance: many residents do not understand WSU financing; CAC was more likely to be able to describe financial processes	Governance: CAC members provide feedback across organizational workgroups; shared voting on Executive Leadership Council	Purpose: specific programmatic decisions (e.g., residents help determine selection criteria and vote on small business grantees)	Purpose: community participation on Planning Committee to define WSU's domains and preliminary strategies	Purpose: Community members voted on WSU's first programs at the annual convening

[a]Adapted from the International Association for Public Participation's (IAP2) Spectrum of Public Participation (SPP); see www.iap2.org
CAC = WSU Community Advisory Committee
Components: purpose, data, financing, and governance
Phases: planning and implementation (includes maintenance)

Findings From Resident and Leader Surveys

For our surveys, 128 West Side residents and 13 WSU nonresident stakeholders ("leaders") answered at least some questions, and 72 residents and 15 nonresident stakeholders completed the entire survey. Overall, one in three (33%) resident respondents and half (47%) of the leader respondents said they were "engaged" or "very engaged" with WSU in the past year; those who completed the survey had slightly higher levels of self-reported engagement.

Table 5 summarizes resident and leader responses for a series of questions about community engagement for each component. Combining these findings with those assessing the frequency and quality of engagement across Goodman's 11 engagement principles, we observed some overarching themes. Many residents and leaders indicated that they did not actually know how well WSU engaged the community for items listed for the data, financing, and governance components. In terms of engaging community members, purpose scored higher than the other elements, for both residents and leaders. Leaders had slightly higher scores for everything except financing; these higher scores were particularly pronounced for governance.

Table 5. WSU Community Engagement by Component (Resident and Leader Surveys)

Rate how well WSU does each of the following		Community Members* (*N* = 69)		Collaborative Leaders* (*N* = 13)	
		Mean Score‡	% Don't Know	Mean Score‡	% Don't Know
Purpose	Considers community feedback in the creation of its vision	3.8	14	4.3	8
	Engages community members in the creation of its focus areas (e.g., economic well-being)	3.6	10	4.2	0
	Considers community feedback when creating its goals	3.7	20	4.1	0

Rate how well WSU does each of the following		Community Members* (*N* = 69)		Collaborative Leaders* (*N* = 13)	
		Mean Score‡	% Don't Know	Mean Score‡	% Don't Know
Data	Includes community members in decisions about which data would be used to measure WSU's progress over time.	3.5	22	3.6	15
	Engages community members in the tracking of data about WSU's progress over time	3.4	22	3.9	25
	Includes community feedback in the interpretation and reporting of data about WSU's progress over time	3.4	22	4.0	42
Finance	Includes community members in financial decisions	3.2	32	3.1	15
	Includes community members in identifying funding to support its work	3.5	30	3.3	23
Governance	Engages community members in creating a WSU Executive Leadership Board	3.4	26	4.5	23
	Considers community feedback when identifying WSU's governance structure.	3.4	29	4.1	23
	Engages community members in the oversight of activities and initiatives	3.5	17	4.2	15
	Considers community feedback when defining its relationships between leaders and stakeholders	3.4	23	4.1	23

*Includes those who gave a nonmissing response

‡Excludes those with missing values or who replied "Unsure/I don't know"; mean on a scale of 1 (poor) to 5 (excellent)

Discussion

Several types of tools came to the forefront as instrumental in building alignment. A strong, understandable visual that told the story of the collaborative's purpose did a great deal to communicate WSU's mission and garner support for its purpose. The data framework was a comprehensive way to tell the story of how WSU would approach its goals from a quantitative perspective and which measures it would evaluate over time. Initial unrestricted funding for staffing allowed WSU to build internal capacity before launching programs. And a governance structure that carried out WSU's value of equal community participation helped build community trust alongside engagement. The document review helped illustrate that alignment activities may vary by domain over time, with an initial flurry of activity to define and communicate the purpose, and financial and data activities developing later in a collaborative's life cycle. The components individually build alignment, but they are also synergistic: A strong purpose facilitated engagement across the other three components, while clear data collection helped members understand whether the purpose was carried out and whether financial resources were used effectively. Independent financing enabled hospitals with different resources to participate equally in governance, which mutually reinforced trust and the institutions' shared interests across the other three components.

Notably, we found differences in how community members and WSU stakeholders perceived WSU's community engagement across each of the components. Generally, WSU leadership thought that WSU had more effectively engaged the community across the purpose, data, and governance components than the community members did. The difference in average scores for individual items was greatest within the governance domain, indicating that the systemic ways in which WSU had attempted to integrate community input (the Community Advisory Council, equal membership on the Executive Leadership Council, participation in the Planning Committee) did not necessarily translate to effective community engagement among community members themselves. These scores also reflect input from the community interviews, which suggested that there was more and broader community engagement during the establishment of WSU and that this broad engagement declined over time as specific, limited engagement processes were created. This may also explain why the highest community engagement scores occurred within the purpose component, which was developed earlier in WSU's timeline.

Utilizing the SPP framework, we also identified discrepancies between how WSU leadership described and perceived engagement and WSU's on-the-ground activities. For example, leadership often described WSU as a community collaborator, but the engagement activities primarily fell within the inform or consult levels. Organizations should carefully consider where they truly want to land in the SPP and then plan community engagement activities intentionally. Landing in the collaborate and empower levels requires relinquishing decision-making control to community stakeholders. Organizations should assess whether they are able to truly do that and, if so, in which contexts. Additionally, organizations may need to explore engagement activities and models that are outside the typical scope. WSU relied heavily on focus groups and community listening sessions, which are familiar and excellent ways of informing and consulting community but do not provide opportunities to transfer decision-making power. Finally, organizations should identify whether their preferred depth of community engagement changes based on the component they are building. For example, it may be more appropriate to inform community members of financial decisions that are largely externally influenced while empowering them to identify the most important measures of change to track.

Next Steps

Other organizations interested in building alignment across organizations but within a specific sector can still rely on the framework to provide guideposts for the required characteristics and components of well-aligned collaboratives. Identifying a few key visuals to tell the story of the mission has a remarkable ability to bring diverse partners to the table, and underscoring decisions with data can reduce members' individual interests in service of a common one. Finally, collaboratives should intentionally plan for community engagement and review their efforts to ensure that they align with the desired engagement level.

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Chapter Four

Synthesis and Conclusion

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How This Book Changes Everything: Key Highlights, Conclusions, and Suggested Next Steps

This book's introduction in chapter 1 revisited the first volume in this series, *Aligning Systems for Health: Two Years of Learning*. *Volume 1* included a review of research on cross-sector health collaboratives, a summary of commentary from practitioners, and a sneak peek at research based on early versions of the Framework for Aligning Sectors, which was developed jointly by the Robert Wood Johnson Foundation (RWJF) and the Georgia Health Policy Center.

Volume 1 consolidated decades of research and practice in health collaboratives and captured the idea that organizations in health care, public health, and social services could work together more effectively through better-shared systems. Even when there is cross-sector collaboration, it is often conceptualized in terms of single initiatives rather than long-term systems coordination, which leaves open a wide range of possibilities for considering larger-scale systems change.[1]

Original research in *Volume 1* suggests that cross-sector health collaboratives often form around a cross-sector need on the part of individuals or organizations, then crystalize around a sense of a shared purpose — for example, wraparound services for a specific subpopulation. *Volume 1* also suggests that shared data and finance systems can promote more effective cross-sector work but can be challenging to implement, especially without some form of shared organizational governance structure to support them. The role of government policy is also highlighted in playing an important, if underexamined, role in shaping cross-sector systems and vice-versa. Research in the first volume also emphasized the potential for community voices to unite collaboratives as well as the difficulties in maintaining partnerships between institutions and community members.[2]

Importantly, different challenges are observed depending on how cross-sector health collaboratives are conceptualized. This is one reason the Framework for Aligning Sectors was developed — to begin refining a shared conceptualization of collaboration around which learnings can be shared and carried forward. In academic terms, this framework is a starting point for creating and testing related theories about how to effectively collaborate. *Volume 1* presented an updated version of the Framework for Aligning Sectors and initiated a dialogue with shared language rooted in that framework.[3]

Volume 1 presented us with many important questions. First and foremost, are health collaboratives that are conceived in terms of the Framework for Aligning Sectors effective? If so, how, why, for whom, and under what circumstances? *Volume 1* made early steps into answering these questions. For example, Hoornbeek et al. at Akron Children's Hospital and Kent State University shared several successes implementing their health collaboration model, which involves community health workers guiding people through health and social services systematically in a model that, in many ways, reflects the Framework for Aligning Sectors. Research like this will shed light on the circumstances and activities most likely to promote better processes and outcomes in different contexts.

Highlights From the Book

Volume 2 picks up on the threads laid out in *Volume 1*. Using the Framework for Aligning Sectors as a lens, or a basis for theorizing, what appears to be working? For whom? Under what circumstances? Below is a list of highlights from the chapters above, provided to underscore some of the key contributions that may help us identify and realize the potentials of cross-sector health collaboratives.

Chapter 1 — Aligning to Respond in Crisis

Chapter 1 is composed of research commissioned to better understand cross-sector health collaboratives in the context of the COVID-19 pandemic. The authors of these chapters observed that organizations with established relationships and shared systems, such as those emphasized in the Framework for Aligning Sectors, were better prepared to respond to the pandemic than they would have been otherwise. McCrae et al. specifically emphasize the importance of (1) pre-existing committees, (2) pre-existing contractual agreements that people felt obliged to uphold even in the chaos of the pandemic, and (3) collaborative data systems. Tuepker et al. highlight the importance of long-standing relationships with collaborative partners, including members of the community at the focus of the work. These types of findings imply a lesson to get started sooner rather than later.

Brewster et al. emphasize not only shared systems but also a shared culture of flexibility. Their chapter suggests that shared systems encourage, or perhaps demand, a level of flexible thinking and action that can prove useful in dynamic situations. One of the key lessons here is that cross-sector collaboration may have helpful unintended impacts on organizational culture by promoting this type of thinking.

Albright et al. also offer a lesson in flexibility. Their chapter offers hope to those lamenting the alienation many people feel from a widespread transition to videoconferencing. At the outbreak of the pandemic, partner participation in their health collaborative dipped, but online communication strategies were increasingly adopted, which facilitated wider access and ultimately may have contributed to increasing partner participation beyond what it had been before the pandemic. While it is important to note that the use of communications technology can stumble on technical barriers in some contexts, especially in low-connectivity environments, it does also hold potential for expanding access to collaborative discussions in some cases, compared to physical access alone.

Taken as a whole, chapter 1 suggests that shared systems can be a strong force for encouraging a systematic focus on shared goals, even in trying circumstances. Notably, the chapters by McCrae et al. and Albright et al. each argue that pre-established systems actually increase dynamism in some cases. These findings contradict the overly simple reasoning that institutionalization inherently prevents dynamism and responsiveness.

Chapter 2 — Measuring Aligning

Chapter 2 comprises research commissioned to take a deeper dive into the conceptualization and measurement of the elements in the Framework for Aligning Sectors. Hoornbeek et al. return and focus on how finance and sustainability are conceptualized and operationalized in their community hubs and in other health collaboratives. They note that finance was often discussed in terms of limited program funding, and they highlight several calls among respondents for Medicaid reimbursement for health-related social services. Their interview participants specifically noted this would offer something for collaborative partners to align around. Hoornbeek et al. also draw out a discussion around incentives, which come from funding in some cases but also take the form of cross-sector learning opportunities as partners learn how to better coordinate their work. The latter

form of incentive is important especially because financial incentives were commonly regarded as insufficient to compel the work being done. This chapter also helpfully addresses accountability, noting that participants in structured hubs had a stronger feeling of mutual accountability than those in less formally structured collaboratives (see chapter 1 for more findings on this theme). Finally, to tie their findings together, Hoornbeek et al. offer *The Progress Continuum in Cross-Sector Financial Alignment for Sustainability* as an aid to those interested in shared funding in health collaboratives.

On the theme of value, Turi et al. focus on how value is defined during focus groups composed of members of cross-sector health collaboratives. They find that members tend to see value where collaboratives engage the communities being served, demonstrate improved outcomes, and create systems change. Collaborative members also thought highly of process measures capturing progress toward organizational change, and this was the type of value most commonly discussed. Turi et al. note that value was more generally discussed at the individual and collaborative level. They also note that people from different sectors tend to talk about value differently, variably emphasizing cost savings, population health, and the costs versus the benefits of collaborative activities. This latter insight underscores the importance of being thoughtful about how different values are honored, even in contexts where there are shared goals.[1]

Salomon et al. take a slightly different approach by asking a panel of practitioners, largely RWJF grantees familiar with the Framework for Aligning Sectors, how equity considerations informed collaborative activities and how equity progress was measured. They offer readers a framework with six considerations for addressing equity in health collaboratives, and they emphasize the importance of funders for driving attention to equity. Practitioners and researchers in the future could compare and find ways to reconcile the latter insight about funders with the idea, gaining traction in some spaces, that funders can promote equity by letting grantees do with their money as the grantees see best fit.

The broadest effort to understand health collaboration through the measurement of the elements of the Framework for Aligning Sectors is offered by Bultema et al. at the Population Health Innovation Lab, who compile and test a survey of over 500 participants in over 20 cross-sector health collaboratives in Washington and California. First, they offer a survey that touches systematically on all core elements of the Framework for Aligning Sectors, and this survey and

several accompanying measurement resources are available to everyone without charge at https://pophealthinnovationlab.org/resources/measurement-toolbox-2/. Second, they conducted 65 interviews and four focus groups to help us understand how people conceive of the concepts in the framework, the measures in the survey, and the relationship between the two. One of several interesting findings is that the "adaptive factor" components of the Framework for Aligning Sectors (community voice, trust, equity, and, especially, power dynamics) are often viewed as related, and perceptions of them can be difficult to measure distinctly. They call for future work to sharpen measurement, analysis, and, ultimately, shared language around the concepts and how they shape health collaboration and its outcomes.

This chapter as a whole should give a jolt to those relying on simple assessments of health collaboratives. Practitioners weave a great many threads of meaning through the elements in the Framework for Aligning Sectors and other frameworks. Carefully establishing shared meaning and capturing what is intended, whether in a collaborative or across the field, will take focus. Shared meaning around terms will also be especially important for understanding causal relationships between different collaborative activities, contexts, and outcomes. Work in this space continues, as seen later in chapter 3.

Importantly, the work in this chapter also contributed greatly to, and provided much of the impetus for, the Toolkit for Everyone Aligning and Measuring (TEAM), which is a set of four tools the Georgia Health Policy Center brought together to help people strategize and measure many of the considerations for health collaboratives brought up here and elsewhere. These sorts of resources can help establish shared understanding both within collaboratives and across the field, enhancing our ability to collectively think about, assess, and understand factors leading to effective collaboration, improved health outcomes, and more equitable processes. The TEAM toolkit is available to all at no charge at www.measuringaligning.org.

Chapter 3 — Adopting Aligning Approaches

Chapter 3 comprises research responding to a more general call for papers that advance our understanding of cross-sector health collaboratives. Several of these studies carry forward discussions on measurement that may help us think more clearly about cross-sector health collaboratives in the future.

Bultema et al. return with an analysis of their survey that links respondent's perspectives toward their collaboratives' levels of alignment in the areas highlighted by the Framework for Aligning Sectors to their ratings of aligning in their collaborative as a whole. The respondents, all members of collaboratives structured on the Accountable Communities of Health (ACHs) model, tended to feel that implementing the ACH model was a benefit to their work. In particular, those who felt their collaboratives were balancing power dynamics well — specifically by including community voices, developing equitable processes, cultivating a sense of shared purpose, and building shared governance systems — also tended to report that aligning efforts in their collaboratives were succeeding generally. Also, those who felt the collaboratives were including community voices, establishing equitable processes, taking care to build trust between partners, and sharing data also tended to report that their collaboratives were advancing equity generally. Like Turi et al. above and Lanford et al. in *Volume 1*, their analysis also suggests that partners with different backgrounds may have very different perspectives on their collaborative, even where there is a sense of shared purpose. These differences may be worth addressing or exploring systematically.

Sanghavi et al. also present findings that are based, in part, on survey results gathered from health collaboratives, this time in Texas. They observe relatively low perceptions of data alignment across sectors, due to factors including interoperability barriers, limited capacity, disagreements about data interpretation, and lack of defined data processes. They perceive even less alignment in financing — a finding that resonates with several other chapters in this book. They also identified an interesting association between power and success, with respondents who felt they had greater decision-making power also feeling that their collaboratives were more successful. Sanghavi et al. also recommended using measures of intermediate outcomes, including access to health care, which may reveal links between factors inside the Framework for Aligning Sectors and the outcomes it emphasizes.

Shapiro et al. offer a unique comparison of health collaboratives using a method that does not rely only on respondent perceptions. In addition to conducting a survey, they do a systematic assessment of the project documents produced by a five-hospital collaborative on Chicago's west side. Judging by the documents collected, they suggest that collaboratives spend vastly more time on developing a sense of shared purpose than shared governance, data, or finance. Data is the

second-most documented of these, which is perhaps not surprising since the collaborative centers on hospitals. Finance, in contrast to shared purpose and data, receives very little attention in terms of documentation.

They also find that partners with backgrounds involving lived experience in the community of focus felt there was less community engagement than did partners with backgrounds in the collaborating institutions. This finding is perhaps not surprising, but it does illuminate a need to interpret the findings reported in health collaborative research with attention to the perspective of different respondent groups who may systematically see things differently.

Another interesting nuance comes in their discussion around community voices. Drawing on their mixed-methods results and the difficulties with institution-community partnerships they observe, they suggest, "collaboratives should intentionally plan for community engagement and review their efforts to ensure that they align with the desired engagement level" (see also Stuart 2014). Importantly this is neither a turn away from community engagement nor a blanket statement dismissive of the many challenges that come along with shared decision-making. Rather, they suggest being intentional, a suggestion that could be compared with elements of the community engagement literature that encourage institutional partners to be *flexible* with their plans for time and money.

Another chapter, which involves a case comparison learning method unique in this book, is offered by Creel et al., who compare rural and urban partnership networks in Freedom House collaboratives in Kentucky. A main contribution is that while rural areas could benefit from the resources obtained by urban organizations, rural organizations do have some relative advantages, in a sense, that can be leveraged, specifically around the closeness of professional and personal ties that come with small populations, greater interpersonal contact, limited resources, and mutual awareness of each other as multirole partners. The rural-urban differences identified may help practitioners tailor their support for different types of contexts.

Smithwick et al. also offer a methodological approach that is unique among contributions to this book. Community health workers were a majority part of the core research team starting from the project design phase. The research team conducted interviews as well as "open mic" dialogue sessions with community representatives in four communities across South Carolina. This study explores common challenges with community-institutional partnerships, and it draws-out potential

solutions that echo those in the broader literature.[1,4,5] They identify trust as an issue and recommend prolonged interactions and partnerships with gatekeepers. They also identify histories of broken promises as an issue and recommend follow-up, follow-through, and acknowledgement of local contexts, culture, and events. A lack of community decision-making in cowork is highlighted as a problem, and they recommend sharing power in all project phases, combined with multiple communication approaches. They also recommend devoting attention to avoiding jargon and time-of-day accessibility issues with gatherings. They note that short-term grant funding and grant imperatives are often not aligned with existing community efforts and problems, and they suggest redesigning funding opportunities and increasing capacity for community engagement. Finally, they recommend careful messaging, flexibility, and creativity in community engagement.

Work following up on the findings in this chapter and elsewhere could explore why these challenges emerge consistently in the literature despite wide awareness of these issues, well-meaning people, and many attempts at some of these same solutions. For example, follow-up work could explore whether the solutions simply have not been tried enough or if there is a different way to look at the problems. Notably, and consistently with the challenges identified, the few existing reviews and systematic texts that assess the link between community engagement and collaborative success tend to find mixed results, weak analyses, and a slight positive relationship between community engagement and collaborative outcomes in some settings.[6-9] These findings depend highly on how the different factors are conceptualized, which again suggests a need to be precise when homing in on different types of community engagement and their outcomes.[4]

Oré et al. also offer a novel and handy analysis, this time concerning the links, and opportunities for future links, between tribal conventions and cross-sector health collaboration. Here, a team of researchers from the University of Washington's Seven Directions tribal public health institute worked with Red Star International, a nonprofit partner focused on indigenous health, and an advisory board familiar with American Indian and Alaska Native health and behavioral health systems. Together, they explored the key components of tribal systems alignment in four tribal partnerships through surveys, weekly meetings, and interviews. They found that the integration of social and cultural perspectives on wellness was important to their tribal community, and they suggested that accountability to the community could be a helpful consideration in the Framework for Aligning Sectors. In terms of organizing and governance, space for lengthy discussion was

valued, while bureaucratic communication was problematized. Interestingly, several aligning projects discussed in the study centered on data and the goal of attaining interoperable data, and this was related to an interest in data sovereignty and its relationship to community power. Respondents also highlighted the importance of cultural heritage integrated with public health efforts, sovereignty in data, patience in communication, and integrated systems that reflect a focus on the whole person and the community.

Finally, Fichtenberg et al. offer a uniquely self-reflective analysis on the challenges experienced when implementing a multisector client referral app in a network of community-based organizations. Even after focused activation of user-informed uptake-increasing strategies, uptake was difficult to increase. This work is exceptional in the sense that it moves beyond suggestions and asks hard questions about why an effort that should work in theory was experiencing practical challenges. This work is effectively testing theory — a crucial step in identifying better solutions. This work creates an important space for future reflection on why reformed systems face challenges with uptake.

Themes and What They Mean for You

This is a large volume that contains a great deal to digest. To help in this process, this section draws out themes that recur across the book and explains why they may be important for your work going forward.

The Benefits of Systems in Place

The first major theme encountered in this book is that people interested in, or already a part of, health collaboratives may benefit from taking a next step in formal and informal relationship building. Several chapters noted that in the face of chaotic situations, pre-existing relationships, whether informal or formal (e.g., contracts), did much to make continued work possible. The benefits mentioned included enhanced capacity to maintain core functions and also enhanced abilities for pivoting collaborative activities quickly. While these studies do not offer definitive tests, these chapters taken together do suggest a link between institution building and dynamism.

The Visibility and Invisibility of Shared Purpose and Finance

It is apparent in these chapters that establishing a sense of shared purpose is one of the most visible activities in cross-sector health collaboratives. The paper trail is much longer, and partners of all types report taking part in activities to promote shared purpose relatively often. Perhaps this is because shared purpose is often established early in collaborative efforts, and this literature is addressing a field where short-term collaboration is conventional and studies focus on early phases of collaboration as a function of grant cycles.[1] In any case, questions arise about whether collaboratives are putting as much effort into other systems, like their shared finance system, as they are putting into their shared visions and also why, and with what consequences.

The relatively low level of attention seemingly dedicated to shared finance (e.g., Shapiro et al) does tentatively suggest that less effort is being put into collaborative finance, but without additional investigation into the subject, the causes and consequences are less clear. It is likely that shared finance requires more difficult power shifts.

Calls for additional financial support are nearly universal, and calls for increased cross-sector funding arrangements are common. This raises questions about what would happen if funding were shared more and restricted less, what an end to calls for additional funding would require, and what additional money would be used for. Fiscal and general accountability between partners cannot be taken for granted, Hoornbeek et al. found, as accountability ratings among partners in health collaboratives appear to be generally low except in the most structured collaboratives. Stepping back, these observations about where collaboratives appear to be devoting their attention raise questions about the level of funding necessary to create impact through cross-sector health collaboration, what will happen in scenarios where greater attention is devoted to collaborative finance, and what specific boundaries present challenges for shared finance.

The Quest for Change in Power and Sovereignty

Collaborative partners with institutional backgrounds almost inherently find themselves in a position to create some level of systems change as a function of their role in delivering services in health care, public health, social services, or some other sector. Often, they also have an interest in systems change to benefit those most in need, even if in their own terms. Yet even in the most

optimal circumstances, practitioners' powers to create healthful change are tempered by large social and structural forces that present obstructions. Further, the perspectives of institutional partners are also likely (if not certain) to differ in at least some ways from the perspectives of other institutional partners and people in the community of focus. It is in this context that both *Volumes 1 and 2* contain calls to amplify decision-making power among those most in need and those who have suffered from unjust historical and current limits on their decision-making power. These volumes also contain interesting ideas about how to do that. Smithwick et al., for example, offer a long list of challenges identified by community partners as well as solutions for addressing them.

Oré et al. take the approach that data promotes knowledge, and knowledge is power. They highlight links between data, knowledge, and power within communities and emphasize how tribal data initiatives have the potential to drive data sovereignty. This insight fits within a broader understanding of integrated and community-sensitive systems as ideally reflecting wholeness, whole persons, and ultimately whole communities. This study could serve as an interesting starting point for future work assessing whether and how collaborative efforts promote wholeness at the individual and community level, and it offers a model for thinking about how integrated data owned and driven by a community can amplify the power of that community.

Getting Specific

While evaluation-style assessments of cross-sector health collaboratives are not new, *Volume 1 and Volume 2* represent early efforts at systematically conceptualizing, theorizing, and analyzing these collaboratives.[10] They do so using the Framework for Aligning Sectors as a much-needed starting point for digging deeply into collaborative experience and identifying effective strategies. A theme observed through both volumes, including by Bulltema et al., is the need to precisely understand subcomponents of the elements highlighted by the Framework for Aligning Sectors. As noted in the review chapter in *Volume 1*, and emphasized throughout *Volume 2*, the elements of the framework are perhaps best understood as important areas of consideration rather than single-variable factors in themselves.[11] These chapters especially emphasize the importance of understanding different dimensions of collaborative finance, governance, power, equity, and community voice. Tools for this have been presented in various forms, for example in The Progress

Continuum in Cross-sector Financial Alignment for Sustainability presented by Hoornbeek et al., the six equity pillars presented by Salomon et al., the Toolbox for Measuring Cross-Sector Alignment presented by Bultema et al., and the TEAM,[12] which draws on all of these. It remains to be seen how widely health collaboratives and those supporting them through research will be able to draw on such tools to usefully clarify and specify relationships between collaborative activities and specific desired outcomes in different contexts.

Our Methods Journey Together

A key purpose for stepping back and examining cross-sector health collaboratives (not just participating in them) is to learn how to make them as effective as possible and share that information with others in similar situations. There are many ways to learn about health collaboratives in ways that promote improved practice. Primarily, studies on health collaboratives, including those in these two volumes, have asked relatively open-ended questions about how collaboratives operate. This has produced a wide variety of insights that suggest success factors and common challenges. In other words, a very large number of theoretical propositions and hypotheses are implicit in this work.

However, in order to know how different ideas tend to stack up, the theories must be compared. This is much easier when cases are compared. When that happens, we gain insight into how differences shape outcomes. This, in turn, provides evidence for, or against, a theory of what promotes collaborative success. *Volume 1* included calls for more theory testing, and *Volume 2*, while still largely a theory building book, did advance the field's ability to test theory. Bultema et al., for example, leverage their survey to compare over 20 health collaboratives, and they find that perceptions of aligning success vary systematically between collaboratives. This is an alert for practitioners, and it opens the door for analyses that ask what drives those systematic differences. Hoornbeek et al. compare a number of hub and nonhub cases and demonstrate higher levels of perceived accountability for improved outcomes in more structured collaboratives. Creel et al. compare sites in urban and rural contexts and identify advantages and disadvantages linked to each context. Many of the other studies implicitly compare cases when they talk about what tends to work or not work.

This work is all well-positioned to advance theory about what works. What will take the work to the next level is for research on health collaboratives to become more explicit about the theory being tested and to design tests of that theory. While this may sound abstract, the practical consequence is that practitioners can more comfortably draw on tested theory about what works while reducing reliance on high-level models and trial and error. If nothing else, more systematic measurement may also help promote accountability among collaborative partners.

Both *Volume 1* and *Volume 2* also contain calls for increased community leadership in cross-sector health collaboratives. The logic is simple: communities have unique insights into their own needs, and these insights may help collaboratives address those needs. Community power may even compel efforts to address the needs identified. Where community voices are stifled, many of the authors in this volume and elsewhere suggest, health collaboratives risk ineffectiveness or even harmfulness. Calls for community leadership extend beyond a focus on practice and into community leadership in research. A key challenge for aligning research going forward then is to find the most effective ways to reconcile the contributions of those with institutional and community backgrounds. The former offer years of professional experience and training, and the latter offer years of direct lived experience at the sharp end of the problems under consideration. This means reconciling, on the one hand, the call above for careful learning across sites and, on the other hand, cases reflecting the types of interest and expertise held by community partners. Solutions offered so far include coleadership in research and practice, capacity building for coresearch among those with both institutional and community backgrounds, early and honest discussion about boundaries to avoid unmet expectations and focus boundary-changing efforts, thoughtful discussion about a project's actual and desired location and movement along continuums of community leadership, and thoughtful discussion about what different partners can contribute to the work, or are interested in contributing given the support available.

There is also, again, the idea that community leadership efforts can look different depending on how they are conceptualized. For example, focusing on health collaboratives initiated by members of a given community may reveal different patterns than if the focus is on health collaboratives initiated in institutional settings. Research on health collaboratives so far tends to take the latter approach, and it might be interesting to see more about cross-sector collaboratives initiated by community groups.

Overall, the methods in this book reflect high interest in community voices. Many of the studies are co-authored by researchers with community backgrounds and/or who devote significant attention and resources to understanding and sharing the perspectives of community members and people whose voices have hitherto been unjustly marginalized.

Many of the studies are qualitative in nature, diving into interview and focus group perspectives on how collaboratives appear to be operating. Yet several studies have quantitative elements as well, with a subset of those being leveraged to identify systematic patterns across sites, partner types, and types of effort. Several studies included realist research elements, integrating a variety of methods and voices from across partnerships to deduce causal linkages between contexts, mechanisms, and outcomes. Creel et al. also implemented a case study comparison drawing on network analyses. Observing *Volume 2* as a whole, a wide range of methods were used. Even the rural-urban analysis by Creel et al. could be interpreted as a quasi-experiment about the effects of context types on the implementation of similar programs.

To summarize, this section offers a wide range of insights for future practice and research, gives reasons for practitioners and researchers to explore new directions hinted at here, and highlights challenges that may need to be addressed depending on the initiative, the learning outcomes desired, and the learning processes used.

What You Can Expect Next

A great deal has taken place since *Volumes 1 and 2* were first conceived. COVID-19 created a world of change, and the pandemic, along with political and cultural change, created an environment that challenges us to re-examine the racial health inequities laid bare once again by COVID-19, the wild economic shocks it compelled in the United States and elsewhere, and our response to them.

Practice and research around the Framework for Aligning Sectors continues through ongoing partnerships between RWJF, the Georgia Health Policy Center, the authors and organizations featured in this book, and many other people interested in practice and research in health collaboratives. This book highlights many potential directions that work could take.

One direction suggested by many of the analysts here and elsewhere is to explore community leadership and efforts to increase equity, especially racial equity, in and through health collaboratives. To that end, RWJF, the Georgia Health Policy Center, the Institute for Women and Ethnic Studies, Aligning Systems for Health partners and sites across the country, and four sites in four U.S. states have embarked on a new project with two main goals: (1) advancing community leadership and equity, including racial equity in particular, in and through cross-sector health collaboratives in those four sites, and (2) learning from this experience to help others do the same with their own partners. Similar efforts are taking place across the world and will give insight into cross-sector health collaboratives as a space to advance community leadership, equity, and racial equity especially.

A goal we can all set for ourselves is that this and other work helps us identify and realize the potentials for cross-sector health collaboratives to create better, more equitable health outcomes, as defined by the communities in focus and those most in need. To that end, the ongoing Aligning Systems for Equity partnership with RWJF, the Georgia Health Policy Center, and the Institute for Women and Ethnic Studies includes continuing efforts to strengthen the community of practice initiated when this book was still in its infancy. Please consider joining this community and being a part of this learning community by emailing aligning@gsu.edu.

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