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Cross-Sector Collaborations And Partnerships: Essential Ingredients To Help Shape Health And Well-Being

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ABSTRACT Cross-sector collaborations and partnerships are an essential component of the strategy to improve health and well-being in the United States. While their importance is unquestioned, their impact on population health has not yet been fully observed. Cross-sector collaboration also is the second Action Area of the Robert Wood Johnson Foundation's four-part Action Framework to build a Culture of Health in the United States. This Action Area has three constituent parts or drivers: the number, breadth, and quality of successful cross-sector partnerships; the adequacy of investment in these partnerships; and the adoption of policies needed to support them. In this article we analyze outstanding examples of partnership-driven work. We also study the challenges of how partner sectors outside the formal health system, such as organizations working in the education or housing sectors, can effectively lead collaborations. We identify models of leadership that maximize the potential of all participants. We also propose the adoption of models better suited to supporting effective cross-sector collaborations. The analysis builds the evidence base for understanding and sustaining the impact of cross-sector collaboration on population health.

The Culture of Health Action Framework, developed by the Robert Wood Johnson Foundation, consists of four Action Areas.¹ The second of these, fostering cross-sector collaboration to improve well-being, focuses on maximizing the power of cross-sector collaboration, particularly with “partner” sectors to health (that is, those beyond health care and public health, such as transportation, economic development, and housing).^{1–3} The fields of community development and public health are interconnected, and the partnership models they use jointly can inform how sectors come together to foster health and well-being.^{4–6} Though both the study of partnerships^{5,7,8} and the use of collaborations for health have grown in frequency and depth in recent years, there

remains a lack of evidence needed to understand which requirements are necessary to nourish and sustain health-promoting collaborations—specifically those with partner sectors in lead roles.^{9–11}

The need for partnerships to promote health and well-being has been established in the literature.¹² However, these partnerships have not been of the scale and duration to influence long-term well-being outcomes at the population level. Continued high prevalence of and growth in preventable chronic conditions such as diabetes and obesity challenge US society to find successful partnership models to address population health.^{13,14} Since these conditions are complex and affected by numerous factors outside the formal health system (for example, availability of parks for exercise, stress of economic

challenge, prevalence of fast food), responses to them should include sectors from outside the health system. Genes and biology, clinical care, and health behaviors (such as tobacco use and physical activity) are estimated together to explain only 30 percent of the variance in health status. The remaining 70 percent is determined by social and physical environmental factors such as access to adequate housing, education, income, healthy food, and safe places for social and physical activity.¹⁵⁻¹⁷ Therefore, involving partner sectors in collaborative work to address these factors is essential, including the sectors' investment in the drivers of health and well-being.

This second Action Area in the Culture of Health Action Framework focuses on three drivers for concerted action to advance effective and sustained cross-sector collaborations: the number, breadth, and quality of successful cross-sector partnerships; the adequacy of investment in these partnerships; and the adoption of policies needed to support them. In this article we describe the three primary drivers; offer arguments for greater focus on each driver; discuss opportunities to extend research and action for each driver; and provide outstanding examples that demonstrate how the drivers have been addressed in successful cross-sector partnerships.

Driver 1: Number, Breadth, And Quality Of Partnerships

More than two decades of community participatory research has provided knowledge about what makes a high-quality, collaborative partnership. One lesson learned by policy makers is that evidence-based research and the resulting knowledge about what works does not change population health outcomes without the essential commitment of stakeholders to engagement, community buy-in, and advocacy.^{18,19}

The need for commitment is manifested by numerous national strategies pushing for engagement of partners across sectors to improve individual and community well-being. Two examples are the Surgeon General's National Prevention Strategy²⁰ and the Healthy People 2020 MAP-IT framework.²¹ Additionally, groundbreaking community health promotion trials from the 1970s to 1990s, including COMMIT (Community Intervention Trial for Smoking Cessation) for smoking cessation²² and MRFIT (Multiple Risk Factor Intervention Trial) for prevention of coronary heart disease,²³ have provided valuable evidence about the core ingredients of effective partnerships.⁸ Among these ingredients are having a clear vision and mission;^{24,25} obtaining appropriate levels of financial investment;^{26,27} and monitoring progress toward

achieving the community's goals so that stakeholders can adjust processes based on intermediate outcomes.^{28,29} These trials also demonstrated that effective cross-sector partnerships improved health behaviors and outcomes at the population level.

One aspect of partnerships that needs improvement is how to engage partner sectors as collaboration leaders, not merely as participants. There are examples of collaborations that have succeeded at this, such as the Communities That Care Coalition (described in further detail below), but recruitment of leadership from across sectors remains a challenge in most community collaborations.³⁰ In traditional health partnerships, leadership is often highly centralized, with a single health organization driving the work and then partnering with other organizations in the community.^{8,31}

To achieve truly effective health partnerships, more widespread use of leadership models that distribute decision making and authority across collaborators is necessary. This distributed decision making maximizes contributions and engagement,^{32,33} as emphasized by the Robert Wood Johnson Foundation's Culture of Health Prize selection criteria, and it addresses the foundation's call for harnessing the collective power of leaders, partners, and community members.

Another potential benefit of using leadership models that distribute decision making is improving equity, which in this context means better balance and representation of historically underrepresented groups. For example, because the general health care workforce does not fully reflect the diversity of the US population in life experience, culture, or economics,^{34,35} health coalitions must be intentional about including partner sectors, such as social service organizations, that can address equity by balancing representation on health issues. In distributed leadership models, equity among collaborators may require active trust building with partner sectors by making sure that each sector benefits from its meaningful participation in a health collaboration.³⁶

Building on a foundation of research findings about what makes high-quality partnerships, research on the first driver should focus on answering questions about models that encourage meaningful participation and leadership from partner sectors and how these collaborations can be mutually beneficial. Future evaluations of such models should examine whether these models encourage stronger participation by underrepresented groups and whether their participation makes a difference in population-level health and health equity

Driver 2: Investment In Cross-Sector Collaboration

Investment in health partnerships has historically come through grants with time and scope-of-work limitations that determine what can be accomplished and when coalitions end.³⁷ Recent systematic evidence reviews to identify what makes community health collaborations sustainable³⁷ have focused on the need for financial maintenance closely aligned with nonfiscal investment (for example, leadership commitment and stakeholder buy-in of the mission). Because the problems that health collaborations struggle to address are complex, they need to identify diverse sources of investment, and their efforts must be sustained over long periods of time.^{38,39} Given these complex problems, providing resources for collaborations to support basic organizational operations (sometimes referred to as “backbone” funding) may improve collaboration sustainability.⁴⁰

A culture of health is expected to emerge over a generation and involve sustained efforts by cross-sector collaborations to address multifaceted, multisystem problems with at least regional-level impacts. While many funders have integrated sustainability in front-end planning now, there are more lessons to draw from partnership science and experiences regarding how to best structure investment mechanisms for more effective sustainment of collaborations. For example, *Aligning Forces for Quality*—sixteen communities working over eight years through regional cross-sector collaborations to improve health—was planned from the start to be funded adaptively and sustainably. It resulted in many instances where local health care processes (such as consumer engagement and communication with patients) were improved.^{41,42}

There are several clear directions for additional research and actions for Driver 2. It may be helpful to know whether or how traditional investments can be coupled with nonfiscal investments such as time and commitment to improving population health and health equity. Future research on funding strategies should identify return on investment, how funding mechanisms can be shaped to address equity, which partner sectors engage and how they do so, and how partner sectors apply and then benefit from health-oriented policy. In terms of actions for this driver, investments across sectors, there are examples where federal, state, and local governments have already begun reviewing policies to make funding decisions that focus on health and well-being integration (for example, the Wellbeing Project in Santa Monica, California).⁴³

Driver 3: Policies That Support Collaboration

Policies that support collaboration seek to foster engagement across sectors to support outcomes of shared health and well-being. The policies that accomplish these outcomes can be implemented at the federal, state, and local levels. Health in All Policies, an approach to improving population health by incorporating health considerations into decision making across sectors, has supported cross-sector collaboration by outlining how government policies supporting such collaboration could be structured, including the consideration of long-term health benefits rather than the more typical consideration of short-term financial costs of programs, and also by assigning health agency staff to intergovernmental decision-making bodies.⁴⁴

To date, implementation of such policies has taken shape through laws or executive orders addressing the actions of federal or state agencies. Some of these require or authorize agencies to collaborate on health issues. Examples include California Executive Order No. S-04-10, which outlined a structure for Health in All Policies collaboration in that state, and the National Prevention Council created through the Affordable Care Act. Laws and executive orders also may assign responsibility to nonhealth agencies to lead or engage in efforts to address a health or well-being issue, or may direct funding to health-related collaborations.^{45,46} Additionally, policies supporting cross-sector collaborations are an essential strategy to improve health equity as discussed by the Association of State and Territorial Health Officials policy statement on Achieving Optimal Health for All.⁴⁷

Regarding research for Driver 3, it will be critical to demonstrate whether and which types of policies actually achieve what was intended (that is, broad governmental decision making that considers health) and whether and how population health is improved as a result. Because governmental policies are not specifically designed to motivate changes in organizational culture and readiness for cross-sector collaboration, enacting legislation to direct government funding to nongovernmental health collaborations comprising cross-sector community organizations may be a mechanism to address this issue.

Cross-Sector Collaboration Examples

This section describes the operationalization of the three drivers, as well as achievement of the core ingredients for partnerships in two cross-sector collaborations. One is a community-based collaboration, and the other is a governmental collaboration with community impact.

COMMUNITY-BASED COLLABORATION The Communities That Care Coalition, in Franklin County, Massachusetts, is an example of a community health collaboration led by two partner sectors to health: a community action group and a community group for teens.⁴⁸ The coalition was formed to address a communitywide problem of high rates of substance use among youth. From the outset of the coalition's formation, a large segment of the community, including local government, businesses, schools, community organizations, clergy, parents, and teens, worked together to plan activities. They developed a vision/mission statement and acquired funding from over twenty sources to address Community Action Plan strategies; both the statement and the funding acquisition are core partnership ingredients. Notably, their funders were as diverse as their coalition, and included federal grants, local business contributions, foundation awards, and state funds. To achieve collaboration equity, the coalition spread decision making across collaborators by creating a Coordinating Council comprising representatives from all sectors of the community, as well as three Workgroups that are the main decisionmakers and implementers of coalition strategies. Between 2003 and 2012, the coalition reduced alcohol use among youth by 37 percent, cigarette smoking by 45 percent, and marijuana use by 31 percent. The coalition monitors these youth risk behaviors through public data and administration of their own surveys with schools.⁴⁹

The Communities That Care Coalition is a successful example of operationalizing Driver 1 (number, breadth, and quality of successful cross-sector partnerships), Driver 2 (investment in collaborations), and core partnership ingredients.

GOVERNMENTAL COLLABORATION WITH COMMUNITY IMPACT The Obama administration commissioned a federal interagency partnership among three federal departments—the Department of Housing and Urban Development, the Department of Transportation, and the Environmental Protection Agency—known as the Partnership for Sustainable Communities.⁵⁰ The policy goals for this partnership were to align cross-agency investments and policies to improve communities (an example of Driver 3's focus on policies supporting collaboration), but through more efficient spending of taxpayer dollars. The partnership's mission makes clear why the three departments were integral to community

development, as it specifies advancing economic opportunity and mobility through the support of transportation connections and promotion of fair housing, all through the lens of helping communities adapt to a changing climate.

Even though this is a federal initiative, the mechanisms of operationalization are well aligned with Driver 1 areas of focus (number, breadth, and quality of partnerships), including the use of local cross-agency Regional Engagement Teams and encouragement of participation from the private sector. Also important is the leveraging of Driver 2 (investment in collaborations) through the 2010 federal investment of \$409.5 million in grants and other types of community assistance through this partnership to support Partnership for Sustainable Communities projects in 200 communities.

Conclusion

Despite the promise of health-focused initiatives with partner sectors in the lead, the nation is still early in understanding how cross-sector partnerships can be optimized as engines for achieving enduring impacts on population-level health, health equity, and well-being. First, collaborations should check whether cross-sector partnerships are truly integrative and whether partners mutually collaborate in advancing health and well-being as part of an ongoing and systematic process; this integration often requires more investment, time-consuming oversight, and maintenance activities.^{37,51} Second, even community-integrated collaborations should be mindful of the lack of equity in representation by the most affected groups. Finally, a greater focus is needed on the support of ongoing collaboration, with particular focus on how partner sectors can be given both financial and other incentives to take a sustained lead in prioritizing health and well-being outcomes.^{52,53}

Given that partner sectors influence the development of communities, they are central to health promotion. Yet they often come into and out of collaborations. They would be better incentivized by policies that fully support collaboration—not just for health care but for all well-being outcomes where partner sectors need to lead. Sustaining a broad coalition of partner sectors and other stakeholders who share an abiding interest in health and well-being will allow for the creation of new mechanisms to achieve a culture of health. ■

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NOTES

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