The Use of Multi-Stakeholder Coalitions to Integrate Healthcare and Social Services

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THE USE OF MULTI-STAKEHOLDER COALITIONS TO INTEGRATE HEALTHCARE

AND SOCIAL SERVICES

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The Use of Multi-Stakeholder Coalitions to Integrate Healthcare and Social Services

Abstract

The United States healthcare system is looking to reduce healthcare costs and improve

healthcare outcomes by traversing traditional healthcare boundaries to address not only the

clinical but also the social needs of patients. Coalitions between healthcare systems, social

service organizations, and government entities are one way to address gaps in the healthcare and

social service systems. The Washtenaw Health Initiative (WHI) is a multi-stakeholder

collaborative in Michigan working to integrate healthcare and social services through use of the

Collective Impact model. Using participant observation and in-depth interviews, this dissertation

aims to 1) evaluate the implications of WHI's alignment with and departures from the Collective

Impact model and other coalition theories and 2) to explore opportunities and challenges for all

coalitions working to integrate healthcare and social services.

The WHI is partially aligned with the Collective Impact model, in that it has a common

agenda of promoting community connections and a strong backbone organization. It does not

strongly align with the other pillars of Collective Impact: shared measurement, mutually

reinforcing activities, and continuous communication. Drawing on other coalition theories, the

WHI may benefit from more clearly defined roles and structure, explicit meeting norms, and a

process for embarking on new activities—including an emphasis on community engagement.

Through these changes, the WHI may become more effective by aligning its approach to creating

change and its activities with its mission.

Coalitions have an opportunity to help providers navigate the tricky interface between

healthcare and social services by sharing and collaborating on different approaches to addressing

patients' social needs. Yet, to effectively address the root causes of social conditions, coalitions

face the challenges of engaging their diverse members, equalizing power dynamics, and building

trust. Overcoming these challenges requires strengthening relationships amongst coalition

members through active facilitation to create an environment to hold difficult conversations

about power, resource distribution, and problems in the coalition's local healthcare system. By

using coalition models to refine processes and structures, multi-stakeholder coalitions can build

an environment which uncovers and addresses the underlying issues that cause gaps in the U.S.

healthcare and social service systems.

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I. Analytic Platform

A. Introduction

My DELTA* project was completed in Michigan, working with the Washtenaw Health Initiative (WHI). The WHI is a multi-stakeholder collaborative consisting of healthcare systems, mental health agencies, social service agencies, and local public health departments. During the DELTA experience, the WHI was in the process of designing the local implementation of the State Innovation Model (SIM), a federal grant to transform the healthcare system in Michigan by creating linkages between medical and social services providers. In this context, I pursued the answers to two questions:

- What are the implications of the WHI's alignment with and departures from Collective Impact and other coalition models?
- What are the specific opportunities and challenges that coalitions seeking to integrate healthcare and social services face that individual organizations do not?

While answering these questions, I explored boundaries and relationships involved in the effort of a multi-stakeholder collaborative to integrate healthcare and social services; I sought to identify common challenges in collaborative work at a system level, inter-organizational level, and small-group level and enumerate possible solutions to some of these challenges; and I tried to delineate the nuances in relationships and conflicting values between stakeholders as the U.S. healthcare providers start to focus on addressing the social determinants of health.

I cannot describe all the dynamics which impact coalition work or every facet that affects the healthcare or social services sector. I decided to bound my work simply by topics with which

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* Doctoral Engagement in Leadership and Translation for Action (DELTA)

I had experience during my DELTA project year. The priority issues I focused on were goals and organizational structure of coalitions, the relationships between coalition members, the differing perspectives across healthcare and social service providers, and the environmental factors influencing these issues.

My dissertation is divided into four major sections: I) Analytic Platform, II) DELTA Guiding Questions, Activities and Methods; III) Results; and IV) Conclusions. In the analytic platform, I begin describing the Michigan SIM and its precursors as well as the local context in the counties where I worked on my DELTA and the host organization at which I completed my DELTA. I then briefly review the separate histories of healthcare and social services in the United States before describing challenges with integrating the two. I end the analytic platform by exploring different theories and practices behind coalition and group work. In the second section, I describe details behind my guiding questions and the activities I undertook during my DELTA, including the process by which I interviewed stakeholders in the WHI as they began SIM implementation. In the results section, I describe the key themes that emerged from these interviews and contextualize them based on evidence from the Analytic Platform and my experience designing the SIM. Finally, in the conclusions, I draw upon the results to answer my guiding questions and suggest areas for future work.

B.   The Michigan State Innovation Model and Its Precursors

Precursors to the State Innovation Model

Two healthcare initiatives were particularly influential to the SIM design: The Michigan Primary Care Transformation Project (MiPCT) and the Pathways Community Hub (HUB) Model. These models are described below.

MiPCT was a multi-payer initiative designed to reform primary care service delivery through payment reform and alignment, standardized clinical and care management models across 345 Patient-Centered Medical Homes (PCMHs), as well as data sharing and alert systems (Bechel-Marriott, 2016). The goals of MiPCT were to "avoid emergency room and inpatient use for ambulatory sensitive conditions, reduce fragmentation of care among providers and involve the patient in decision-making" ("MiPCT Demonstration Project," n.d.). MiPCT was able to show net savings based on averted medical care; however, the savings likely occurred in the Medicare population, in hospital admissions rather than the Medicaid population and in emergency department visits—due to the different reasons that those populations used medical services (Bechel-Marriott, 2016). This model formed the basis for the PCMH-arm of the SIM described below.

Pathways Community Hub Model

The HUB has been implemented in three counties in Michigan (Michigan Public Health Institute, n.d.). The HUB uses community health workers (CHWs) to coordinate care for "at-risk" individuals through home visits, appointment accompaniments, and a comprehensive health assessment to identify "behavioral health, as well as social, environmental and educational factors" (Pathways Community HUB Institute, Community Care Coordination Learning Network, 2016, p. 3). Clients are referred from healthcare and social service providers to a central community hub, which houses CHWs. After risk factors are identified, CHWs navigate individuals down coordinated "pathways" to address those risk factors. One of the strengths of the HUB model is that a single person can work with an at-risk individual to address multiple pathways, as opposed to having a different person in the community responsible for each

separate pathway. Notably, however, "the HUB model primarily focuses on individually modifiable risk factors but can provide important data about the population's health as well" (Pathways Community HUB Institute, Community Care Coordination Learning Network, 2016, p. 3). The HUB model is the State of Michigan's recommended model for SIM CHIRs to address the population of frequent emergency department (ED) users.

Michigan State Innovation Model

The Michigan SIM is a $70 million grant from Center for Medicaid and Medicare Innovation (CMMI). There are five regions in Michigan to receive the funding to implement this model over three years: Washtenaw and Livingston counties; Jackson County, Genesee County, Muskegon County; and Northern Michigan (10 counties). The first year of the SIM (July 2016-July 2017) is a planning year, during which my DELTA took place. The second and third years August 2017-July 2019) of the SIM are implementation years. The model is designed to transform Michigan's healthcare system through two arms: PCMHs and Community Health Innovation Regions (CHIRs).

PCMHs in the Michigan SIM

The PCMH arm of the Michigan SIM is largely a continuation of the MiPCT demonstration project for Medicaid patients. PCMHs will continue to receive a per member per month payment for care coordination and practice transformation, depending on the population served; however, the payment will now be distributed through the Medicaid Managed Care Organizations (MMCOs). PCMHs must conduct a social needs screening tool with their Medicaid patients. They must refer patients to social services, and track if those referrals are actually completed. They also must participate in the state's health information exchange, which includes a provider directory, documentation of active care relationships between patients and

providers, and notices for when patients are admitted or discharged from a hospital or emergency room.

Community Health Innovation Regions

The governance model for CHIRs prescribed by the state is derived from the Collective Impact framework. The CHIR backbone organizations are coalitions of community organizations, government, businesses, and healthcare systems who partner to improve the health of the community. In Washtenaw and Livingston counties, where I completed my DELTA, the backbone organization was the WHI, discussed in more detail below. The purpose of the CHIRs is to provide a linkage between healthcare and social services. To that end, CHIRs must develop an intervention, based on the HUB model, to integrate the two sectors. During the first implementation year (beginning August 1, 2017), CHIRs must focus their intervention efforts on frequent ED users. The intervention is intended to be one that builds local capacity for integration and coordination.

C.   Local Context and Host Organization

Local Context

Washtenaw and Livingston County Background Data

Washtenaw and Livingston counties have approximately 360,000 residents 190,000 residents, respectively. In Washtenaw County, 74% of the population are white, 13% are African American, 9% are Asian and 4.5% are Hispanic or Latino (U.S. Census Bureau, n.d.-b). In Livingston County, 97% of residents are white (U.S. Census Bureau, n.d.-a). About 14% and 6% of people are living below the poverty line in Washtenaw and Livingston Counties, respectively. In Washtenaw County, over 50% of people have a bachelor's degree or higher, and in Livingston County, that number is 33% (U.S. Census Bureau, n.d.-a, n.d.-b). In both counties

about 55% of residents are obese or overweight, and around 10% have reported mental health status as fair or poor (St. Joseph Mercy Ann Arbor, 2015; St. Joseph Mercy Livingston, 2015). Transportation, affordable housing, and dental care access are also reported barriers to health. Respectively, 14% and 10% of residents are on Medicaid in Washtenaw and Livingston Counties (Michigan Department of Human Services, 2015).

Local Institutions

In Washtenaw County and Livingston counties, there are three major health systems: Michigan Medicine (MM), St. Joseph Mercy Health System (SJMHS); and Integrated Healthcare Associates (IHA). MM consists of an academic tertiary-care hospital and outpatient clinics associated with the University of Michigan. SJMHS is a catholic health system associated with Trinity Health. It operates three hospitals is Washtenaw and Livingston counties. SJMHS and MM had traditionally been competitors; however, through the Washtenaw Health Plan (described below) and the WHI, they have come together in the spirit of collaboration in recent years. IHA is a provider group of 560 providers in 33 specialties operating in the two counties. IHA is also owned by Trinity Health and its providers operate in SJMHS. There is also a Veteran's Affairs Hospital located in Washtenaw County.

Washtenaw County has one federally qualified health center (FQHC), Packard Health. They do, however, have several other safety-net providers. IHA, in particular, has expanded the number of Medicaid patients it serves since the expansion of the Medicaid in Michigan. There are numerous non-profit organizations in Washtenaw County. One common complaint from the non-profit sector is that there are too many non-profits in Washtenaw County. The Washtenaw Coordinated Funders (funded in part SJMHS as well as other funders) seeks to solve this problem by helping to coordinated nonprofits through directed funding. Livingston County does

not have that same problem. They have a strong social service coordinating body called the Human Services Collaborative Body. Livingston County also has several faith-based and church-based non-profit services.

As a precursor to the WHI, the Washtenaw Health Plan (WHP) brought both MM and SJMHS together to cover hospital and specialty services for indigent Washtenaw County residents. The WHP was historically funded through Disproportionate Share Hospital (DSH) payments.   Since the passage of the Affordable Care Act (ACA), the WHP has focused its efforts on enrolling people in Medicaid and coordinating care for low-income individuals in Washtenaw County. It has worked in collaboration with the WHI. Members of the WHP board sit on the WHI steering committee, and employees of WHP participate in WHI work groups. The two organizations created a joint document, delineating the work of the WHP as primarily with agencies that serve the low-income individuals, and the WHI as a convener of institutions to improve healthcare for low-income individuals by helping to design a new community health system.

The FUSE program brings together housing agencies, health systems, the health department, community health centers, mental health providers, and homeless shelters to provide housing stabilization, intensive case management, and are coordination to homeless individuals who frequently use the ED (Center for Supported Housing, 2016). In Washtenaw County, the program receives $200,000 in funding from the Social Innovation Fund, and matched funds from the Washtenaw County Coordinated Funders, SJMHS, and Washtenaw County Community Mental Health (WCCMH). The program used data from health systems, homelessness

information system, and WCCMH to identify frequent users for the intervention. The program costs are $11,394 per client, over half of which is made up of rental subsidies (Center for Supported Housing, 2016). The evaluation of the reduction and services and cost savings are still pending, but initial analysis of the data appear to show savings in the highest users.

The FUSE program has enrolled approximately 200 individuals to-date who frequently used the ED and provided them with housing and intensive case management services. The project is only focused on chronically homeless individuals as defined by the Department of Housing and Urban Development ("Changes in the HUD Definition of 'Homeless,'" 2012). The FUSE program is run out of Avalon Housing and the projected was adopted by the WHI. Key lessons from the FUSE program have been 1) it is extremely difficult to get data from different health systems and combine it to create a usable list; 2) regular quality assurance meetings are important to program success; 3) only the highest cost individuals are the individuals where cost savings can be realized; and 4) frequent ED users require very intensive services (multiple home visits per week) at a level that health system providers are not familiar with. The work of FUSE lays some of the ground work for the design and implementation of the SIM intervention.

The Center for Health Research and Transformation

The Center for Health Research and Transformation (CHRT)'s mission is to encourage health systems transformation and inform the state and national health care reform dialog by promoting evidence-based care delivery, working to improve population health, and helping to improve access to care. From 2008-2015, CHRT was funded jointly by Blue Cross Blue Shield of Michigan (BCBSM) and MM. In 2015, the funders announced that they would no longer provide hard funding to CHRT, and that beginning in 2017, CHRT would have to search for

funding from other resources. This has led CHRT to shift its efforts to focus more on searching for funding through grants and consultation services.

The Washtenaw Health Initiative

Overview

As a part of this mission, since 2011, CHRT has been facilitating the WHI, a voluntary collaborative of over 80 organizations focused on increasing healthcare access for low-income individuals. Organizations involved in the WHI are MM, SJMHS, WHP, IHA, other provider groups, health clinics, WCCMH, Washtenaw County Public Health, Avalon Housing, mental health providers, United Way, BCBSM, faith-based organizations, senior supportive service organizations, and other social service organizations. Member organizations must sign a WHI charter and have it approved by their boards. Notably, the WHI is not a separate 501(c)(3), and CHRT serves as the fiduciary for the WHI.

The WHI was originally created in 2011 to help plan for implementation of the ACA in Washtenaw County—specifically, to help ensure there would be enough providers to meet the anticipated increase in demand due to increased health insurance coverage.   Since then, WHI has evolved to address other healthcare gaps within Washtenaw County, such as providing access to dental services for those without access and increasing the use of an overdose reversal medicine in partnership with the County Sheriff's department. When the ACA was implemented in 2014, the WHI began the process of searching for new purposes. The implications and outcomes of this search are described below in the results section.

Since its inception, WHI has been funded through reoccurring contributions from local hospitals' community benefit grants, Washtenaw County government, Ann Arbor city government, BCBSM, and smaller contributions from other local funders. WHI's 2016 budget

was for $156,000—excluding money from SIM and the approximately $196,000 of in-kind support from CHRT for organizing and facilitating WHI activities.

WHI was recently selected to participate in the Michigan SIM (described above) as the backbone organization for Washtenaw and Livingston counties. Over the course of 3 years, from July 2016 to July 2019, the WHI will receive approximately $3.4 million through the SIM grant, much of which will be distributed to organizations in Washtenaw and Livingston counties. In the past, the WHI has only received money from other organizations to coordinate and implement projects. The WHI has never been a position to distribute a significant amount of money to other organizations and, it has never had a budget greater than $400,000 (including CHRT in-kind staffing). Additionally, although WHI has a 5-year history of working in Washtenaw County, it does not have experience working in Livingston County. The WHI will have to navigate these new endeavors with the additional complicating factor of the change in CHRT funding.

WHI Operating Structure

WHI Steering Committee

The WHI Steering Committee provides oversight and direction to the WHI. It makes the final decisions on the which projects to take on, where funding should be distributed, as well as providing advice and direction to projects and work groups. The Steering Committee has 20 members: 11 of whom are either currently or formerly associated with health systems; two of whom are associated with local mental health agencies; one of whom is a former county administrator; one who is the Washtenaw County Public Health Officer, one who is a public health professor, one who is from the business community, one who is the former treasurer of the University of Michigan, one who is from the United Way of Washtenaw County; and one who is

the executive director of CHRT. The current co-chairs of the steering committee are the former treasurer from the University of Michigan and the former CEO of MM. The steering committee meets monthly.

WHI Work Groups and Projects

The WHI has five work groups: the Primary Care Work Group; the Mental Health and Substance Use Disorder Work Group, the Community Coordination and Dental Work Group; the Medicaid & Marketplace Outreach and Enrollment Work Group, and the SIM Work Group. The work groups, for the most part, meet monthly. Some work groups have project teams or subcommittees, whose meeting frequency varies. The work groups are responsible for identifying gaps in the community and for overseeing projects, and for reporting to the steering committee. Work groups generally have co-chairs, who are selected based on availability and expertise.

WHI Stakeholder meetings

WHI stakeholder meetings occur 3-4 times per year. The purpose of the stakeholder meetings is to inform the broad group of WHI stakeholders on the activities, to highlight individual projects, and to receive input from WHI stakeholders on the direction of WHI. The stakeholder meetings are generally attended by about 70 people, with representatives from many, but not all of the WHI member organizations.

WHI Goals and Evaluation

Goals

The WHI has five goals. The following is taken directly from the WHI website.

With a primary focus on the low income, uninsured, and underinsured people within Washtenaw county:

1. Increase insurance coverage of uninsured individuals.

2. Help those with Medicaid coverage and/or those who are underinsured maintain that coverage, understand it, use it more effectively, and/or find access to care.

3. Improve coordination and integration for health care services.

4. Align entities engaged in delivery of health-related services to more efficiently and effectively utilize resources.

5. Strengthen community wide efforts to improve care and services for mental health and other select health issues and/or select populations. (Washtenaw Health Initiative, 2015)

These goals were created in 2014, when the WHI reexamined its purpose after ACA implementation. Each work group also has goals, which I will not detail here.

Previous Evaluation and Member Survey

The WHI had previously undertaken a series of interview evaluations in 2013, and a member survey in the spring of 2016. The strengths of the WHI identified in the survey were: its ability to convene many stakeholders; and its ability to provide information to stakeholders that helped them to provide better services. The areas for improvement identified in the 2016 member survey were: communication about decision making processes and activities were insufficient; the WHI contributed to increasing the duplication of services; the WHI did not measure its programs effectiveness and did not help members do the same; and the WHI did not involve members of the communities whom it seeks to serve. I used the results of this survey to develop follow-up questions for my WHI interviews (described below in the Guiding Questions, Activities, and Methods section).

D. The Broader Context of Healthcare and Social Services

The WHI is situated within the larger context of the U.S. healthcare and social service systems. Its existence is a response to the passage of the ACA in 2010. Its funding primarily comes from the community benefit division of the region's two major hospital systems. In this era of healthcare transformation, where payers are seeking to compensate hospitals and providers based on value rather than fee-for-service, the WHI facilitation of hospital efforts to address the social determinants of health may improve the value of their healthcare services. One way to for hospitals to address the social determinants of health is to seek to better integrate healthcare and social services—which have historically been funded and delivered separately. To contextualize the WHI and the SIM, below I describe 1) a brief the history of the separate paths by which healthcare and social services were developed in the United States; and 2) the current healthcare environment relevant to the funding and delivery of healthcare and social services.

The Separate Paths of Healthcare and Social Services

A Brief History of Hospitals, Healthcare Services, and Insurance

Hospitals evolved from almshouses: institutions providing care and respite to the poor and needy (Rosenberg, 1995). Since their patients rarely had money to pay, hospitals rarely charged much above the cost to provide care (McGregor, 2006). Wide-scale health insurance developed in the 1930s and 1940s, and was largely tied to employment (Scofea, 1994).

Medicaid, when it was passed in 1965, was based on the English Poor Laws (which also influenced the development of social welfare) (Orentlicher, 2015). Thus, until the ACA, the only people who were eligible for Medicaid were the "deserving or worthy" poor—children, adults with children, or the disabled (Orentlicher, 2015). Medicare, in contrast, was modeled after Social Security, whereby everyone at certain age was eligible, regardless of income or

worthiness (Oliver, Lee, & Lipton, 2004; Udow-Phillips, 2017). In 1986, congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires that EDs provide appropriate medical treatment to any individual, regardless of citizenship, legal status, or ability to pay. EDs, thus, are required to treat everyone, regardless of whether they have an emergent condition or not. This requirement was motivating factor for hospitals to support the ACA, because they had to see many patients who did not have insurance, for whom they would not receive reimbursement for services (Udow-Phillips, 2017). DSH payments were also created in 1986 to provided extra funding for hospitals who served poorer patients. As the health insurance system grew, providing reliable payments to hospitals, hospitals pricing incentives changed. There have historically been efforts to control healthcare costs, particularly those in Medicare, since the 1970s. The ACA galvanized these efforts through the focus on population health (described below).

A Brief History of Social Services

The history of social services in the United States is much more decentralized than that of healthcare, but is still largely connected to employment, as well as to the idea that those who receive welfare, are likely to become complacent and not seek employment. Morris (2000) states that social work has two aims: 1) working with individuals and 2) improving the conditions in which individuals live. These two aims, which lead to questions of defining the boundaries of social work, are pervasive throughout its history.

> The goals of social welfare programs derive from the goals of the larger society for itself and from the view that society holds of itself and of its various members. In turn, decisions about who is needy and how they are to be helped bear upon economic development, political organization, social stability, and family integrity. Social welfare

programs involve a redistribution of resources from one group to another. Our political

culture has often resisted using government to redistribute resources, relying instead on

the private economy to care out this function. Through much of our history, Americans

have valued private assets over public goods and individual autonomy over collective

choices.(Stern & Axinn, 2012, p. 2)

Similar to Medicaid, social welfare in the United State derives from the English Poor

Laws (Stern & Axinn, 2012).   The programs were always designed to aid those who were poor

and unable to work—the ill, children, widows, and the elderly (Stern & Axinn, 2012). In the late

1800s and early 1900s, due to a lack of government programs, private charity organizations

formed, which provided the modern foundation for social work: "including casework,

educational and training programs, and the individualization of services" (Stern & Axinn, 2012,

p. 95). Today, social services in the United States are largely delivered by private organizations

and financed through private foundations, donations, or government grants.

Comparing Social Work and Medical Professions

Social work is a profession aligned with the poor. It is essentially, when not focused on

individual therapy, a program which attempts to couple the lives of the poor with the lives of the

well-off. Social work and social welfare are redistributive programs. Medicine, as a profession,

has not historically been aligned with the poor, and has not focused on the redistribution of

resources. There is a recognized social contract between society and physicians, but in general,

that contract extends to the bounds of the physician's office and treatment of individual patients,

and excludes social issues (Cruess & Cruess, 2004). There have historically been and currently

are calls for aligning medicine with the poor, including a focus on social justice. In 2002, the

American Board of Internal Medicine Foundation released 3 principles of the medical

profession, one of which is the principle of social justice: "The medical profession must promote justice in the health care system, including the fair distribution of health care resources" (American Board of Internal Medicine Foundation, 2002). Kirch and Vernon (2009) recall that justice is one of the four pillars of medical ethics, but that it often gets deemphasized due to an overemphasis on the pillar of patient and physician autonomy. As the WHI brings together healthcare providers and social service providers in efforts to address the social determinants of health, it is paying witness to the struggle to redefine the boundaries of what healthcare provider organizations are responsible for.

Current Healthcare Context: The Affordable Care Act, Population Health, and Role of Hospitals

The Affordable Care Act

In 2010, the ACA was signed into law, with most of its changes scheduled to take place in 2014. The ACA expanded Medicaid to everyone making up to 138% of FPL. When the ACA was enacted and Medicaid was expanded, this was the first time at a federal level that Medicaid became insurance for the poor, instead of just those who were worthy (Orentlicher, 2015). In a Supreme Court case, this expansion was later made optional to states (Kaiser Family Foundation, 2013). At the time of this dissertation, 31 states and Washington D.C. have expanded Medicaid eligibility (Kaiser Family Foundation, 2017). As a result of this expansion, DSH payment (which previously funded the WHP) were set to be phased out in 2014, but partially due to the fact that states were not expanding Medicaid, this has been delayed until 2018 (Buettgens, Holahan, & Recht, 2015).

Health System Transformation

The ACA created the CMMI, a division of the Center for Medicare and Medicaid Services (CMS) specifically designed to test and implement payment models and care delivery

models to improve quality and reduce the cost of healthcare services. The ACA has spurred a payment reform effort across the United States. Payment incentives are now moving towards paying for value—that is measurable improvement in health outcomes, use of best practices, and patient satisfaction—instead of paying solely in a fee-for-service model—a model which rewards providers for seeing more patients without taking into account the quality or outcomes of services. The SIM is funded through CMMI.

Current U.S Health Spending, Outcomes, and Population Health

As a part of this overall push to transform the health system, the concept of *population health* has become widespread. A 2016 Commonwealth Fund report compared health outcomes in the United States to those of 11 other high-income countries. In almost all health metrics, the United States ranks last (Osborn, Squires, Doty, Sarnak, & Schneider, 2016). The United States has a lower life expectancy, higher infant mortality rates, a greater percentage of the population with multiple chronic conditions, (David Squires & Chloe Anderson, 2015; Osborn et al., 2016). The study also notes that individuals in the U.S. are more likely to be worried about being able to buy food and pay for housing (Osborn et al., 2016)—two social determinants of health which may be addressed by the integration of healthcare and social services. Moreover, the United States spends 17% of its GDP and over $9,000 per capita on healthcare, the highest of any country (David Squires & Chloe Anderson, 2015). This high spending has been attributed to multiple causes: higher fees paid to physicians and hospitals (Laugesen & Glied, 2011), greater use of expensive technology (David Squires & Chloe Anderson, 2015), and "super-utilizers" of healthcare services (Gawande, 2011). In a 2015 study, Johnson et al. found that although the characteristics of super-utilizers are consistent at a population level—characteristics such as race, the number of chronic conditions, being uninsured or having Medicaid—the individuals who are

super-utilizers are not consistent over time (Johnson et al., 2015). This suggests that individual super utilizers are not necessarily the cause of high healthcare spending, but rather they are symptoms of a health system that fails to address their needs. Super-utilizers are particularly pertinent to my DELTA project, because of the Michigan SIM's focus on frequent ED users.

To contextualize the health outcomes and health and social service spending in the United States, it is important to define *population health*. Kindig and Stoddart (2003) defined population health as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." In their original article, they suggest that the field of population health should examine not only health outcomes and distribution of a population, but also the interventions, policies, social and environmental context, interventions and policies that shape those health outcomes (Kindig & Stoddart, 2003). Since 2003, the populations in *population health* have been defined either by a clinical population which a provider or payer is responsible for, or by geographic regions. Kindig (2015) suggests that "defining population health in terms of clinical populations draws attention away from the critical role that non-clinical factors such as education and economic development play in producing health." Instead, he says, we should use the terms *population health management* or *population medicine* for clinical populations, and reserve *population health* for geographic-defined populations, "which are the concern of public health officials, community organizations, and business leaders" (Kindig, 2015).

Adopting this idea of population health (or population health management), the Institute for Healthcare Improvement developed what is widely known as "The Triple Aim": improving population health, improving the experience of care, and lowering per capita healthcare costs" (Berwick, Nolan, & Whittington, 2008). In their article, Berwick et al. (2008) note the

preconditions for achieving the triple aim: "recognition of a population as the unit of concern, (2) externally supplied policy constraints (such as a total budget limit or the requirement that all subgroups be treated equitably), and (3) existence of an 'integrator' able to focus and coordinate services to help the population on all three dimensions at once." The idea that the "integrator" should be responsible for the provision, experience and cost of healthcare services formed the basis Accountable Care Organizations (ACOs).

ACOs and risk

ACOs are groups of clinicians and institutions that provide coordinated care for a defined population and assume some degree of financial responsibility for the cost of that care. ACOs are responsible for a defined population and are held accountable for cost, quality, and health outcomes. Even if ACOs are effective in reducing healthcare spending and improving the quality of healthcare services, it is uncertain how this will improve coordination and resources distribution between healthcare and social services (E. S. Fisher & Corrigan, 2014a). In order to truly address the social and environmental health determinants, the concept of Accountable Health Communities—a volunteer, self-financed, collaboration that aligns community and clinical services—has emerged (E. S. Fisher & Corrigan, 2014a).

Medicaid Managed Care Organizations Programs

Though distinct from ACOs in that they do not provide direct care to patients, MMCOs in Michigan are being pushed towards ACO-like efforts in their contracts with the state of Michigan (such as the requirement that MMCOs in Michigan work with mental health providers to create interventions targeting high utilizers). MMCOs are critical to the sustainability of Michigan's SIM interventions. The State of Michigan and the WHI believe that MMCOs may be able and willing to fund the SIM interventions after CMMI funding runs out. MMCOs may

have incentives to provide address the social determinants of health. However, Gottlieb, Garcia, Wing, and Manchanda (2016) note several challenges to doing so:

> Despite the apparent alignment of these structural characteristics with low-income members' unmet social needs, there are multiple challenges limiting MMCOs from expanding social services. New prevention services are not easily incorporated into MMCO-state capitation agreements, so MMCOs have to cover any additional benefits out of administrative or community benefit dollars. Coding practices and other administrative requirements for MMCOs can also make it difficult to adopt new prevention services. Furthermore, any financial return related to social service investments may take many years to realize, which can decrease the financial feasibility of adoption. Finally, MMCO care delivery models, financing contracts, and organizational structures (which may span several states) can make community collaborations and public partnerships—often critical to a comprehensive approach to social service delivery—more challenging. (Gottlieb et al., 2016)

In their review of MMCO programs to integrate medical and social services, Gottleib et al. (2016) described programs that focused on a target population based on demographic characteristics (e.g. race), utilization patterns (e.g. high cost, high-utilizer), health conditions (e.g. asthma, diabetes, multiple chronic conditions), or specific social needs (e.g. food, housing, employment). Evaluation of these programs was sparse, although when evaluated, some programs found reduction in ED visits and hospital admissions, cost savings as well as greater patient satisfaction (Gottlieb et al., 2016). Notably, evaluation of health outcomes was absent.

Prior to the SIM, community benefit was primarily how the WHI was funded. Even with the SIM, the participation of the hospitals in the WHI is largely a function of their community benefit. To understand how the WHI might continue to be funded, it is important to understand how community benefit is conceptualized from a hospital perspective.

Community Benefit

Since hospitals evolved from poorhouses, they have generally been viewed as providing a benefit to society. Non-profit hospitals are exempt from taxes, and in exchange for this benefit they are expected to provide benefit to their communities. "Community benefit" is a term which was ill-defined historically and allowed for great variation in the interpretation by hospitals (Sara Rosenbaum, 2016a). Notably, just being physically present in a community as a hospital is not sufficient to qualify as a community benefit; the hospital must "demonstrate that they are involved in activities recognized by the IRS as benefiting their communities" (Sara Rosenbaum, 2016b, p. 2). ACA regulations added additional community benefit stipulations for hospitals—notably requiring that they conduct community health needs assessment (CHNA) every three years with an accompanying implementation plan (CHIP) updated yearly. The WHI has facilitated a joint CHNA and CHIP between MM and SJMHS, the two hospital systems in the county.

There is no specified dollar amount of community benefit that hospitals must provide. The national average of non-profit hospital expenditures directed to community benefit as a proportion of total expenditures is estimated to be 9.7% (S. Rosenbaum, Kindig, Bao, Byrnes, & O'Laughlin, 2015). Nationwide, this totals to $62 billion in 2014. Rosenbaum et al. (2015) estimated that non-profit hospitals receive a total of $24.6 billion in tax benefits in 2015.

Comparing this $24.6 billion figure of tax exemption to the $62 billion figure of community benefit spending looks favorable. However, 92% of that $62 billion figure is for hospital-related activities, leaving only 8%, or $4.7 billion, for non-hospital related activities (S. Rosenbaum et al., 2015). Corrigan, Fisher, and Heiser (2015) suggest that community benefit activities should be more regionally focused, reserving funds for investment by regional backbone organizations and that community benefit programs should be measured to evaluate their effectiveness. This could include investing in multi-stakeholder coalitions to integrate healthcare and social services, such as the WHI.

Defining a Hospital's Community

While carrying out community benefit activities, a hospital must define its community. It is always a challenge to appropriately define a community, and to define a community of a hospital is no different. A "community" has historically been defined by relationships and identity based on a sense of place, typically a neighborhood boundary (Walter & Hyde, 2012). In community-based participatory research (CBPR), community has been defined as:

> a unit of identity. Units of identity refer to membership in, for example, a family, social network, or geographic neighborhood, and are socially created dimensions of identity (Steuart, 1993). Community, as a unit of identity, is defined by a sense of identification and emotional connection to other members, common symbol systems, values and norms, shared interests, and commitment to meeting mutual needs (Steuart, 1993).. (Barbara A. Israel et al., 2005)

Communities are not static, but rather a dynamic set of relationships, whose quality determines how much "communityness" really exists (Walter & Hyde, 2012). Communities are made up of individuals, and each individual may belong to multiple communities (Labonte,

2012). Communities should not exist to be intervened on, but rather communities can be

engaged with in a mutual process of change, whereby individuals in the communities,

community practitioners (or hospital community benefit employees), and organizations

(including hospitals) all change as a result of this engagement (Walter & Hyde, 2012).

Community engagement is discussed more in depth in Coalitions and Organizational Behavior

section.

Many hospitals choose to define their community as broader than a geographic

community in which its main facility is located. They may define their community as the

geographic region to whom they provide services. Some hospitals see themselves as providing

services to residents all over the state, country, or even the globe. Additionally, they view the

training they provide to physicians and the research produced as a benefit to their community. It

is important to note that the definition of community for a hospital includes not only the spatial

or professional identities, but also the hospital's relationships (or lack thereof) with other

organizations. Regardless of the hospital's definition of its community, one way to define how a

hospital should allocate its community benefit activities could be proportional to the tax benefits

that it receives from being a non-profit.

It has been suggested that in addition to reporting financial contributions to community

benefit, hospitals should also be required to report population-level health measures (Rubin,

Singh, & Jacobson, 2013). Due to the challenges of linking population level outcomes to hospital

community benefit programs, especially in geographic regions with multiple hospitals, hospital

managers are hesitant to be held accountable for population-level health outcomes (Rubin et al.,

2013). One intermediate step may be to directly link CHNAs and CHIPs to community benefit

spending (S. Rosenbaum et al., 2015; Sara Rosenbaum, 2016b; Rubin et al., 2013). Community

benefit activities may align with payment reforms including risk-based contracts through ACOs; however, from a short-term, financial perspective, if community benefit programs successfully reduce service utilization in a primarily fee-for-service payment model, they may actually result in reduced revenue for hospitals. Moreover, even if hospitals would like to take on more risk, insurers appear reticent to give them this risk (or potential revenue) (Livingston, 2016). From a more holistic view, if hospitals view the communities around them as potential patients, patients who, if healthier, are more likely to be employed, and thus more likely to have insurance, reducing hospital expenditures on charity care (Robert Wood Johnson Foundation, 2013). This view is similar to concept of "anchor institutions."

Hospitals as Anchor Institutions

In recent years, the concept of "anchor institutions" has been introduced by The Democracy Collaborative, housed at the University of Maryland:

> …nonprofit or public employers such as universities and hospitals—often referred to as "anchor" institutions—have increasingly become the economic engines of their communities. As the word "anchor" implies, anchor institutions, once established, rarely move location. In large measure because of their community (nonprofit or public) ownership, these anchors are truly tethered to their communities regardless of the prevailing economic winds; their mission, invested capital, and customer relationships bind them to their communities. (Zuckerman, 2013, p. 1)

This notion implies that hospitals are anchor institutions, whether they consciously embrace the term or not (Zuckerman, 2013). If hospitals do embrace their role as anchor institutions, the goal is to shift "the discussion of community benefit from the margins of an institution's operations to overall accountability, where all resources can be leveraged to benefit the communities in which

institutions are located (Norris & Howard, 2016, p. 2)."   The Democracy Collaborative

describes the reasons it sees for why hospitals should adopt an anchor institution strategy. This

strategy:

> 1) aligns with a hospital's mission, 2) generates economic returns to both the community
>
> and institution, 3) helps satisfy its community benefit requirements to the federal
>
> government, and 4) provides an opportunity for a hospital to justify its tax-exemption and
>
> reduce its financial burden to local governments. (Zuckerman, 2013, p. 2)

E.   Integrating Healthcare and Social Services: Current Thinking and Challenges

Defining Health and Social Service Integration

The distinction between healthcare services and social services is not always clear. For

this dissertation, I adopt the definitions of healthcare and social services used by Bradley and

Taylor (2013). They define healthcare services as:

> public and private spending on curative care, rehabilitative care, long-term care,
>
> laboratory and diagnostic services, outpatient and preventive care, and public health
>
> services (Elizabeth H. Bradley & Taylor, 2013, p. 16).

 Social services are defined as:

> public and private spending on old-age pension and support services for older adults,
>
> survivors benefits, disability and sickness cash benefits, family supports, employment
>
> programs (e.g., public employment services and employment training, unemployment
>
> benefits, supportive housing and rent subsidies), and other social services that exclude
>
> health [services] (Elizabeth H. Bradley & Taylor, 2013, p. 16).

The definition of the integration of these services ranges from "coordinating, collocating, or

restructuring services or programs (Hassett & Austin, 1997) to consolidated systems of

information management (Gregory, 1996), and numerous forms in between" (M. P. Fisher &

Elnitsky, 2012, p. 444).

Motivations to Integrate Healthcare and Social Services

The field of public health and many individual healthcare providers have historically

understood the interaction between health and environmental and social conditions (Elizabeth H.

Bradley & Taylor, 2013; Bynum, 2008; E. Sydenstricker, 1933), yet, it is only in the last few

years that the U.S. healthcare system has begun to embrace this concept on a wide scale. In

2011, the Robert Wood Johnson Foundation published *Health Care's Blind Side* (2011)*.* The

report found that:

- 85% of physicians say the social needs directly lead to worse health;

- 87% of physicians believe that this is a problem for everyone, not just low-income

  communities; and

- 76% of physicians believe that the healthcare system would pay for costs associated with

  connecting patients to services that address their social needs

Historically, the reasons for integration have been to achieve efficiency—reduction in

cost through appropriate service provision setting and reducing service duplication—and

efficacy—better care and outcomes (M. P. Fisher & Elnitsky, 2012). Bradley and Taylor

describe two additional interrelated reasons for integrating social services and medical healthcare

services: cost and provider experience.

Cost as a Driver to Integrate Healthcare and Social Services

Bradley and Taylor (2013) suggest that the reason the United States spends so much

money with such poor health outcomes is that we spend relatively little money on social services.

In their book, *The American Healthcare Paradox,* Bradley and Taylor (2013) suggest that when combining social service spending and healthcare spending, the United States actually spends 25% of its GDP on health and social services, whereas many other countries spend over 30% of their GDP on health and social services combined. Moreover, the ratio of health to social service spending in the United States is much higher than other countries—indicating that perhaps we should shift our spending from healthcare to social services (Elizabeth H. Bradley & Taylor, 2013). In a more recent study supporting this conclusion, Bradley et al. (2016) finds a correlation between the state-level spending on healthcare and social services and health outcomes. Although many acknowledge that social service spending should be boosted, "policy makers are unlikely to make substantial new budgetary commitments to social services. Therefore, facilitating investments in social services by private health systems and health plans may be the best available approach at this time" (Abrams & Moulds, 2016).

Health and Social Service Providers' Experiences as a Driver to Integrate Healthcare and Social Services

The cost of healthcare is only one of the drivers pushing healthcare providers, payers, and policy makers to examine the interrelationship between health and social and environmental conditions. The experience that healthcare providers have on the ground and their lack of ability to care for some of their patients inside the four walls of the clinic or hospital is causing them to look at the socioeconomic environment of their patients, and thus, into the realm of social services (Elizabeth H. Bradley & Taylor, 2013). Due to EMTALA, hospitals must serve individuals who show up in their emergency room. They cannot avoid patients who come to their emergency room because of social needs, needs that cannot be appropriately addressed in the hospital. Not only do the hospitals bear the costs of these patients, but the healthcare providers themselves experience the stress and frustration of being unable to provide services to

their patients, patients whom they cannot ignore. Bradley and Taylor point out that frontline providers in both health and social services are stretched thin as a result of inadequate investment in social service, and although both desire a more holistic approach to health, there are many challenges to effective collaboration between the health and social service sectors (Elizabeth H. Bradley & Taylor, 2013).

Common Challenges with Integration

There are several common challenges in integrating health care and social services that I detail below based on a review of the available literature and examples.

Incomplete View of Individuals

Many integration efforts do not consider the complexity of the individuals and communities they are working with. The way that insurance works is to pool payments and spread risk. This lens narrows the view individuals into two dimensions: the quantity of financial contributions to the insurance pool and the level of risk for of healthcare spending. However, this viewpoint does lend itself to viewing the person as a whole, a person who has values, priorities, and needs. In many payer-driven reforms, only the motivations of the providers are considered—the perspectives of individuals receiving are notably absent.

Short Time Horizon

Capacity building takes time. In integration efforts, this includes establishing partnership structures, hiring and training staff, and establishing data-sharing agreements (Massachusetts Department of Public Health, 2016). In addition to the time it takes to integrate services, the time frame for observing cost savings is at least many years—as was the case in the Health Homes Project in Seattle (J. W. Krieger, Takaro, Song, & Weaver, 2005)—and possibly a decade or more. Many people may not be on the same insurance over that time frame, thus, making

insurers disinterested in programs that take a long time to mature. The only people who have incentives to care for them over the long-term, are the geographic areas themselves (e.g. county and city governments) and anchor institutions (hospitals and universities). Finally, some interventions themselves, such as the Camden Coalition's interventions 90-day intervention (Brenner, 2010), are so short, it is hard to envision a long-term effect of their intervention, even if there is a short-term positive effect.

Integration Interventions' Scopes Are Too Broad, or Too Narrow.

The problem of scope is one that mires efforts to integrate healthcare and social services. Fisher and Elnitsky (2012, p. 461) state that "successful human services integration efforts are likely to focus on limited geographical and political spaces and should not attempt to include the entire range of services available." On the other hand, funding is likely available for programs with specific designs known at the outset, limiting the ability of programs to adapt and grow as they learn (M. P. Fisher & Elnitsky, 2012). The key, is getting the scope of the program broad enough to push the boundaries of health and social work, but not too broad so the project becomes unmanageable. This mirrors the problems faced by the fields that are attempting to integrate: the medical field has often been too narrow, excluding important health-related factors, and the social service field has often been too broad, crippling its ability to meaningfully act.

Excessive Focus on Cost Savings

Many of the efforts to integrate healthcare and social services do so on the premise that money will be saved. This limits the range of interventions that may be discussed. Interventions that focus on addressing the more upstream determinants of health, may not save money, but that doesn't mean they are not worth doing from a population health or cost-effectiveness perspective

(Cohen, Neumann, & Weinstein, 2008). The following quotation describing the benefits of

Housing First, a homelessness prevention program, describes this dilemma:

> creating expectations of cost savings imposes a double standard. In general, there's no
> expectation that health and social services save money. Instead, we invest in treatments,
> programs, and services that deliver benefits at an acceptable cost, often judged on the
> basis of quality-adjusted life-years gained. Insisting on net savings from Housing First
> programs implicitly devalues the lives of homeless people (Kertesz, Baggett, O'Connell,
> Buck, & Kushel, 2016).

While quality-adjusted life years may be one way of attempting to view the integration of

health and social services, Social Return on Investments (SROIs), as a counter measure to ROI

that accrues to private organizations, is an alternative way of viewing the integration of medical

and social services that might help with the focus on cost savings. SROIs are used to evaluate or

predict the economic impact of an intervention across social, economic, and environmental

realms (Fischer & Richter, 2016; Nicholls, Lawlor, Neitzert, & Goodspeed, 2012). This broader

outlook may allow for more interventions to be viewed as costs saving as well help society view

cost savings that are distributed across many groups, as opposed to those that accumulate only in

one organization or sector (Fischer & Richter, 2016). There have been relatively few SROI

studies in the United States (Bhaumik et al., 2013; Moody, Littlepage, & Paydar, 2015). This is

perhaps due to the large number of assumptions that must be made to calculate SROI, the need

for extensive data collection and stakeholder engagement where data is not typically collected

and stakeholders are not typically engaged, and the lack of actual cash return on investment

(Moody et al., 2015).

Challenges with Accurate Data and Referrals

Many integration efforts struggle to obtain adequate data to measure the problems they are seeking to address, to utilize data to improve programs, and to appropriately measure programs to determine their success. For example, the lack of standardization between hospital electronic health records make the scaling up of referral technology between hospitals and community organizations difficult (Nasuti, 2015). Furthermore, quality improvement requires its own infrastructure and support for the partnerships in the Massachusetts Prevention and Wellness Trust Fund (Massachusetts Department of Public Health, 2016). In hospital readmission penalties, hospitals may be held responsible for what they cannot control such as community resources (Joynt & Jha, 2013), which might unfairly penalize them. Although, the argument could be made that hospitals should in fact seek to control some of those community resources. Finally, where data is not easy to obtain, interventions may not be attempted, even if this is where they are most needed.

Limited Insurance Billing

As of now, there are limited ways for many social service providers to bill insurers for services. FUSE providers can only bill through a Medicaid code as a subcontract of WCCMH (Center for Supported Housing, 2016). That means, if a patient does not qualify for WCCMH—having Medicaid and severe and persistent mental illness—the social service providers cannot bill for their case management services. This inflexible billing limits the services that can be delivered. Additionally, there are limits to what health insurance will pay for. In the Healthy Homes project in Seattle, they received donations for items that insurers would not pay for (J. W. Krieger et al., 2005). As a potential solution to this, in the Oregon SIM model, Medicaid was able to pay for flexible services (Hale, 2016), which may be a model for other states to follow.

It remains to be seen whether this current push to integrate healthcare and social services is of a different character than previous efforts to do so, and if it will result in meaningful change in the healthcare system that actually address people's social needs, particular those social needs for the marginalized and low-income populations. Many are hopeful that, "with this confluence of sound economics and good policy, investments in interventions that address patients' social as well as clinical needs are starting to make good business sense" (Bachrach, Pfister, Wallis, & Lipson, 2014, p. 17).

F. Coalitions and Organizational Behavior

Below I define coalitions, review the Collective Impact model and associated literature, as well as describe key concepts from other coalition models. I also describe select concepts from organizational behavior literature, which are informative for understanding the work that must take place for coalitions to function.

Coalitions Defined

For purposes of my dissertation I will adopt the following definition of a coalition: "an organization of diverse interest groups that combine their human and material resources to effect a specific change the members are unable to bring about independently" (Brown, 1984, p. 4). More simply put, a coalition is "an organization of organizations working together for a common purpose" (Himmelman, 2001, p. 277).

Wandersman, Goodman & Butterfoss suggest two common purposes for coalitions:

(1) coalitions are service-delivery mechanisms that can generate and implement needed strategies in a community and therefore produce public health and other outcomes, and

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(2) coalitions are collaborative systems-change agents that influence the delivery of

intervention strategies among existing community agencies and organizations.

(Wandersman, Goodman & Butterfoss 2008)

Wandersman, Goodman & Butterfoss (2008) state that they believe that using to "mediate social

structures" is the best way to view coalitions (purpose 2 described above) and that using

coalitions to deliver services may not be the best use of coalitions. The authors don't state the

reason for this preference, but I would extrapolate that they feel that service-delivery functions

can often be completed by simpler organizational structures, and when simpler structures can

complete the task, coalitions should not be formed (F. Butterfoss & Kegler, 2012).

In her review of coalition history, Butterfoss (2007) describes three different approaches to

coalitions: *the social work approach, the activist approach,* and *the community development*

approach. Rothman similarly describes three mechanisms of community action: *policy and*

planning, social advocacy, and community capacity development (Rothman, 2007). Below I

describe and integrate these approaches and action mechanisms.

- *The Social Work Approach/Policy and Planning*: Coalitions members seek to band

  together to coordinate, deliver, and lobby for social services and social services resources

  (F. D. Butterfoss, 2007). Change occurs through the power of pooled resources. In this

  approach, data are used to "convey the truth as revealed in empirical facts, which should

  lead toward proposing and enacting particular solutions" (Rothman, 2007, p. 12). This

  planning can be done rationally at the level of policy makers, or may be done using a

  participatory planning process that is less deterministic in its outcome (Rothman, 2007).

- *The Activist Approach/Social Advocacy***:** Coalition organizers seek to mobilize members

  around a key issue in order to create policy and shift power dynamics related to that issue

(F. D. Butterfoss, 2007). This approach is sometimes described as the Alinsky approach, after Saul Alinksy, a prominent community organizer in the 1930s who later wrote the *Rules for Radicals* (Alinsky, 1971). Change occurs through the creation of conflict with organizations that may lose power, and the attention that is drawn to those conflicts. Pressure may be applied in different ways: militant actions, using data, or member solidarity and demonstrations (Rothman, 2007).

- *The Community Development Approach/Community Capacity Development*: Community members are assumed to have the resources and capacity to deal with their own problems if they actively participate to solve those problems. "Change is best accomplished when the people affected by the problems are empowered with the knowledge and skill needed to understand their problems, and then work cooperatively together to overcome them" (Rothman, 2007, p. 12). In this approach, change occurs proactive consensus building, peer pressure and through the education and empowerment of community members. This is similar to what Martison and Su (2012) describe as the Frierian approach, after Brazilian educator Paul Friere.

Keeping these approaches in mind, I enumerate the components of the different coalition models below. I focus first on Collective Impact, because that is the purported model of the WHI and the Michigan SIM grant. I later describe other coalition models as well as the group dynamics underlying the interactions between individual coalition members and coalition organizations.

Collective Impact

The idea behind Collective Impact is that many of the larger problems in our society cannot be solved by one organization alone, but that solutions must come from the coordinated

action of multiple organizations through mutually reinforcing activities (Kania & Kramer, 2011). Specifically, Collective Impact is "the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem"(Kania & Kramer, 2011). Collective Impact is contrasted with what is termed "Isolated Impact," the traditional model by which funding agencies provide grants to non-profit organizations—a model in which none of the funding organizations nor the other non-profit organizations competing for funding are communicating with one another. This approach most closely aligns with the social work/policy and planning approach to coalitions. In their description of Collective Impact, Kania and Kramer identify five attributes to successful models of change: 1) a common agenda; 2) shared measurement systems, 3) mutually reinforcing activities, 4) continuous communication, and 5) backbone support organizations (2011).

Common Agenda

Common Agenda can be defined as ensuring that there is a shared understanding of the problems the coalition seeks to address and the strategies by which to address those problems— including the roles and responsibilities of each partner organization.

Shared Measurement

Shared Measurement is used to clearly define the success of the collaboration. A short list of common indicators are collected by agencies throughout the community in order to measure success, ensure alignment of activities, hold one another accountable, and learn from the activities (Kania & Kramer, 2011).

Mutually Reinforcing Activities

The activities of stakeholders should be coordinated, rather than uniform. "Each stakeholder's efforts must fit into an overarching plan if their combined efforts are to succeed.

The multiple causes of social problems, and the components of their solutions, are interdependent. They cannot be addressed by uncoordinated actions among isolated organizations" (Kania & Kramer, 2011).

Continuous Communication

Kania and Kramer (2011) describe continuous communication as a process by which trust is built up amongst stakeholders. This happens through regularly meetings (at least monthly, if not more frequently), with structured agendas and neutral, skilled facilitators (Kania & Kramer, 2011). Communication should be occurring between stakeholders outside of regular meetings, either through email or through the coordination of activities. Communication and trust take time to build, and only through seeing the commitment of organizational CEOs through their attendance and follow-up can members see their shared organizational interests may trump the interests of individual organizations.

Backbone Organization

Backbone organizations should be neutral conveners. They assist with coordinating, facilitating and following-up on meetings. They also assist with "technology and communications support, data collection and reporting, and handling the myriad logistical and administrative details needed for the initiative to function smoothly" (Kania & Kramer, 2011). In their original article, Kania and Kramer identify the need for backbone organizations to have staff which are separate from that of stakeholder organizations (2011):

In the best of circumstances, these backbone organizations embody the principles of adaptive leadership: the ability to focus people's attention and create a sense of urgency, the skill to apply pressure to stakeholders without overwhelming them, the competence to

frame issues in a way that presents opportunities as well as difficulties, and the strength

to mediate conflict among stakeholders (Kania & Kramer, 2011).

Collective Impact in the Literature

Collective Impact is attractive because it offers a model by which we can address some of

society's biggest problems. It does not claim to be a silver bullet; however, it does present itself

as if there is a "known formula" for solving complex social problems. Its foundation, as Thomas

Wolff points out in his critique, is based on selective case examples rather than systematic

evidence (Tom Wolff, 2016). He continues that "in light of the uncritical, widespread adoption

and funding of Collective Impact by government agencies and foundations, it is necessary to

examine and assess Collective Impact much more critically and thoughtfully"(Tom Wolff,

2016).

Indeed, most of the evidence and opinions around Collective Impact come from the

Stanford Social Innovation Review, in which Kania and Kramer published the first Collective

Impact Model, or from the grey literature—from organizational white papers, blogs, or other

editorials. There are some articles published in peer-reviewed journals described below.

A few journal articles discuss how they used the Collective Impact framework in their

coalitions (Amed et al., 2015; Flood, Minkler, Hennessey Lavery, Estrada, & Falbe, 2015;

Gwynne et al., 2016; Klaus & Saunders, 2016; Meter, 2016). Of the above articles, only Flood

et al. has a direct, detailed discussion of the pros and cons of the Collective Impact model in their

framework (Flood et al., 2015). They state that Collective Impact was useful for galvanizing

multiple stakeholders to action, and it was important to develop a common agenda with their

diverse coalition members to ensure activities were carried out. However, they note, Collective

Impact lacks involvement of those most affected by the issues and lacks a focus on policy and

advocacy (Flood et al., 2015). The coalition was aware of these drawbacks as they began and were able to integrate local residents and advocacy into their coalition work (Flood et al., 2015) by combining Collective Impact with the Butterfoss' (2007) Community Coalition Action Theory (CCAT).

Amed et al. (2015) explicitly combine Collective Impact Model with CBPR principles—principles which include:

- Facilitates collaborative, equitable involvement of all partners; and

- Promotes a co-learning and empowering process that attends to social inequalities. (B. A. Israel, Schulz, Parker, & Becker, 1998)

This combination of Collective Impact and CBPR may have helped to mitigate Collective Impact's lack of focus on community engagement, community development, and equity. Similarly, Klaus and Saunders (2016) supplement their use of Collective Impact with theories of community participation (Shediac-Rizkallah & Bone, 1998) and community leadership (Guo & Saxton, 2010).

Meter (2016) discusses how the Collective Impact model has been used in co-ops in Minnesota, describing departures from common agenda and mutual reinforcing activities. The author states that these departures, the model is useful because they have been able to adapt it to their needs to create an environment of mutual accountability and critical thinking (Meter, 2016). The use of Collective Impact as a model may help coalitions create the environment necessary for societal improvement. Mutual accountability and critical thinking are much more analogous to group processes that are important for coalitions to succeed rather than, as Wolff (2016) critiques, conditions (such as a Common Agenda) which are required of all coalitions

One article states that the authors used the Collective Impact framework in their initiative, but give no detail on how they used it or its impact on their outcomes (DeGregory, Chaudhury, Kennedy, Noyes, & Maybank, 2016). Some other articles discuss the promise of Collective Impact, and relying on programs cited by the original authors as evidence for effectiveness (Aragón, Garcia, & Population Health Division Leadership Team, 2015; Boyce, 2013).

Since the Collective Impact article was originally published in 2011, Kania and Kramer have begun to address some of Collective Impact's major critiques (2016). In particular, they state that the original 2011 publication lacked sufficient emphasis on equity, community engagement, and policy change (Kania & Kramer, 2016). From a health perspective, equity can be defined as a health disparity that is unfair or unjust, requiring dedicated resources for those who are systematically disadvantaged (Braveman & Gruskin, 2003). Community engagement can be defined to mean engaging those most affected by issues which the coalition is seeking to address (Tom Wolff, 2016). This can happen through consultation, but ideally, community engagement involves shared decision-making power. "Coalitions without grassroots voices are very likely to create solutions that do not meet the needs of the people most affected by them and treat people disrespectfully in their community change process."(Tom Wolff, 2016). As a result of the literature and criticism of Collective Impact, Cabaj and Weaver (2016) propose to broaden and shift Collective Impact core attributes to: Community Aspiration; Strategic Learning; High-Leverage Activities; Inclusive Community Engagement; and Containers for Change.

Key Concepts from Coalition Literature

There are many other coalition models, some of which have a longer history than Collective Impact (Berkowitz, Hulberg, Standish, Reznor, & Atlas, 2016; F. D. Butterfoss, 2007; F. Butterfoss & Kegler, 2012; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001;

Himmelman, 2001; Norris, 2013; Roussos & Fawcett, 2000; Thomas Wolff, 2001; Tom Wolff et al., 2017). In the section below, I review some of the lessons and concepts from these coalition models that are relevant the WHI.

Coalition Formation, Goals, and Vision

Among the most important factors in a coalition are the formation, goals and vision. The motivation for the coalition should come from within the community; however, resources often come from external sources, and thus it may be difficult to form a collation solely with internal resources (Thomas Wolff, 2001). The vision and mission of a coalition must be clear to participants and relate to the day-to-day activities of the coalition (Thomas Wolff, 2001). The mission and vision, along with coalition activities, should be reevaluated at least yearly, by at least the governing body if not the whole coalition (Thomas Wolff, 2001). This practice helps keep coalitions "fresh, alive, and responsive to community and organizational needs" (Thomas Wolff, 2001, p. 178).

Structure and Convening Organization

Coalition structure is a paramount to determining a coalition's success. Many coalitions have convening organizations—similar to the backbone organizations described above. The convener of the coalition serves as the initial recruiter and the initial meeting host for the coalition (F. D. Butterfoss, 2007). This convener must have "sufficient organizational capacity, commitment, leadership, and vision to build an effective coalition" (F. D. Butterfoss, 2007, p. 77). The convener "must recruit community gate keepers, those committed to the issue, and a broad constituency of diverse groups and organizations" (F. D. Butterfoss, 2007, p. 78). Coalitions should make an effort to recruit diverse memberships, in terms of expertise, constituencies, sectors, perspectives, and backgrounds" (F. D. Butterfoss, 2007, p. 78).

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Butterfoss (2007) also note the importance of staff who have the necessary skills to facilitate these processes, as well as the adoption of formal structure and rules in coalition success as it matures.

The core functions of the convening group or individual must be clearly defined. "If not, such a structure eventually may evolve into taking the leadership role or acting from its own interests" (Tom Wolff et al., 2017). The convening roles are:

- Securing and providing expertise and resources

- Coordinating member activities

- Serving as centralized communication source

- Managing administrative details (Tom Wolff et al., 2017)

These roles may be fulfilled by more than one organization. It is also important to clarify roles for decision-making as well as to communicate activities—a process which builds member engagement, trust, and ownership (Thomas Wolff, 2001).

Membership Engagement and Coalition Leadership

Membership of coalitions is determined by who participates (Thomas Wolff, 2001). Coalitions may be exclusive—based on power roles within the community—but those that are most effective are coalitions that are inclusive and diverse from the start (Thomas Wolff, 2001). CCAT notes that is important to engage members through these processes: "member engagement is best defined as the process by which members are empowered and develop a sense of belonging in the coalition" (F. D. Butterfoss, 2007, p. 82). Leadership of coalitions is distinct from leadership of hierarchical organizations. In coalitions, responsibility and leadership are more dispersed. A coalition's facilitating structure must also take into account power dynamics

among coalition members (and non-members). Membership engagement in inclusive collations requires collaborative leadership:

> Collaborative leaders share power rather than impose hierarchy; they take a holistic look at the organization and the community rather than fragment or departmentalize; they focus on facilitation and process versus decision making. They are flexible rather than controlling, decentralized rather than centralized, inclusive rather than exclusive, proactive rather than reactive, and they focus on process and product rather than product only. At the core, collaborative leaders need to be risk takers (Thomas Wolff, 2001).

Community Engagement

Is his book, the *Power of Collaborative Solutions,* Wolff (2010) describes the benefits of community engagement: community groups can communicate with individuals that outsiders cannot, a process which can reveal informal community leaders, overlooked knowledge of what has and has not worked in the past, as well as potential novel solutions. Additionally, engaging the community members can promote ownership of a project, making it more likely to succeed, and can help build local capacity. From the community's perspective, those outside the community who are looking to engage the community offer only one of many options that may meet a community's needs (Tom Wolff, 2010). Wolff (2001) makes the distinction between community-based and agency-based initiatives (first described by Florin and Chavis (1990)):

> In the agency-based coalition, the intervention comes from professionals and institutions in the community, and citizens are secondary players. In community-based coalitions, the community is at the core. In this case, community members identify the issues, analyze the problems, select the interventions, and deliver the interventions and the evaluation. (Thomas Wolff, 2001)

In a community-based coalition, communities are viewed as a place where people live and communities have control and ownership over problems and solutions (Tom Wolff, 2010). Conversely, in an agency-based coalition, communities are viewed as the site of the problem and the tool for adapting services and disseminating information (Tom Wolff, 2010).

Labonte (2012) notes that community engagement is more than bringing programs of larger institutions into "community" settings. Rather, community engagement and community development requires larger institutions to support community groups to solve a problem that the community group defines, with a solution that community group defines (Labonte, 2012). Butterfoss (2007) notes that just because there is a coalition, it does not mean that the coalition reaches community members or is grassroots. There must be extensive outreach and serious effort in order to engage these groups (F. D. Butterfoss, 2007). To fully realize community engagement, institutional effort must be expended to prepare authority figures to engage meaningfully with one another (Tom Wolff et al., 2017). Meetings should be facilitated in ways that avoid technical language and professional jargon, which can serve to dampen, rather than raise community engagement.

Collaborative Empowerment or Collaborative Betterment

Building on the concept of community engagement, Himmelman (2001) describes coalitions as either seeking change through *collaborative empowerment* or *collaborative betterment.* In a collaborative empowerment coalition, the coalition is started from within the community and the community controls decisions and ownership. Collaborative betterment coalitions are started from outside the community, and are managed by members outside of the community. Himmelman continues that coalition exist on a continuum between collaborative empowerment and collaborative betterment, and coalitions can transform between the two poles.

Collaborative betterment coalitions are not designed to transform power, and in fact many coalitions are funded because they do not threaten existing power relations (Himmelman, 2001). He contends that how governance structure in coalitions either reinforces or transforms power relations should be discussed explicitly (Himmelman, 2001).

Power Dynamics in Coalitions

Collective Impact initiatives seek to address the complex problems of society and as such, often their solutions require the changing of power in a community (Ryan, 2014). Power dynamics in a community have been built up over time, often when many of the wielders of power, unaware of this structure (Ryan, 2014). Over this time, the system becomes interest in supporting itself, in maintaining the status quo power dynamics (Ryan, 2014). In order to address these power differentials, Mary Jean Ryan (2014) suggests using collective frustrations to create common ground between constituencies that often don't work together. However, as Himmelman notes, in order to change power, you must have power (Himmelman, 2001). Wolff et al. (2017) believe that Collective Impact's hierarchical model recreates and reinforces power dynamics that lead to inequities in society.

Ellis and Walton (2012) note that in order for health departments to engage in genuine partnerships with their communities, they must give up the power of control over the outcomes of their projects. This can be done explicitly and voluntarily from those who currently have power—a mechanism which requires substantial goodwill—or it can be done through outside pressure (Ellis & Walton, 2012). Outside pressure is one of the key components in other coalition and organizing theories (Alinsky, 1971; Labonte, 2012; Rothman, 2007). Like Himmelman (2001), other coalition thinkers note that in order to address power dynamics,

coalition members should acknowledge their power differences (Christens & Inzeo, 2015; Labonte, 2012; Tom Wolff et al., 2017).

This will require, for instance, careful self-examination around issues of race, with the white members of the collaborative examining white privilege and systemic racism as they play out in the collaborative and in their work. This is not just a cognitive activity—it requires reengaging the heart as a professional development strategy for racial justice (Tom Wolff et al., 2017).

If they fail to acknowledge power dynamics, those with power "risk making invisible to types of power they do hold 'over' community groups, however, thereby increasing the risk of abusing that power" (Labonte, 2012, p. 101).   The authors of Collaborating for Equity and Justice coalition framework note this is a specific challenge with power differences related to racial, ethnic and class-based inequities (Tom Wolff et al., 2017). They note that many coalition models may actual serve to recreate structural racism and classism, and that unless these issues are explicitly addressed at the center a coalition, it is likely that they will be at best, ignored, and at worst, perpetuated.

In coalitions whose goals are to improve their communities through community development, implicit in this goal is the necessity that some groups must be chosen over others (Labonte, 2012). Labonte makes the distinction between "support groups" and "community groups." He notes that while support group work may involve creating equal power dynamics from those that are around the table, community groups seek to create equal power dynamics at the institutional level by making private discussions, public conversations (Labonte, 2012).

That coalitions or certain groups within coalitions do not have power, Heifetz (1994) believes, can be used to their advantage. First, the person or group without power does not have

to provide solutions to a community—as the groups with power often are expected to do (R. A. Heifetz, 1994). This allows for more creative deviance, one which may disrupt the current environment (R. A. Heifetz, 1994). Second, without power, you can focus attention on a single issue, as opposed to having to meet the needs of different stakeholders presenting multiple issues. Third, without power, you often are closer detailed experiences of those in the situation, what Heifetz calls *frontline information* (R. A. Heifetz, 1994).

Conflict

When coalitions seek to change power, conflict often results, especially in the Activist/Social Advocacy approach. Mizrahi and Rosenthal (1993) believe that conflict is an inherent part of coalition processes. Wolff (2001) notes is important to create a space where conflict can be managed collaboratively and productively, but not eliminated. Conflict in collaboration can be for useful for less powerful groups to establish legitimacy (Gray, 1989); to keep powerful stakeholders in check as negotiations and collaborations are under way (Labonte, 2012); or to bring light to issues that may have been getting in the way of achieving the coalition's goals (Dukes, Piscolish, & Stephens, 2008; R. A. Heifetz, 1994). In substance use coalitions, those that addressed conflict openly were more successful (Kaftarian & Hansen, 1994). Heifetz says that "the inclusion of competing value perspectives may be essential to achieving success" (R. A. Heifetz, 1994). Heifetz (1994) argues that if the *holding environment*—the relationships which contain the stresses brought about by conflict—is strong, then conflict can move a group forward (discussed more below). Applied to coalitions, a strong holding environment may be composed of strong relationships between coalition members, internal or external pressure to come to a solution, and the members' belief in the common goals

bringing them to the table. However, if that holding environment is not strong enough, the stresses will break through, and the coalition may fail (R. A. Heifetz, 1994).

Group Effectiveness and Meeting Principles

Ostrom (1990) notes that group effectiveness is not a function of the size of the group, but rather how visible the actions of the group are to other members of the group. Butterfoss (2007), similarly concludes that the group size of coalitions is not as important as how the group size is managed and how the work is divided and then reintegrated. Coalition work must occur inside and outside of meetings, but meetings are where members of the coalition come together to make decisions on coalition planning, action, structure. Butterfoss describes key meeting principles to have an effective meeting:

1. Spend sufficient time preparing and clarifying the purpose of the meeting

2. Start with introductions ground rules, review the agenda, follow the agenda, take minutes, and record unfinished discussions.

3. Involve as many people as possible during the meeting.

4. Make sure everyone understands what is going on through summarizing discussions.

5. Stay on time.

6. Assign action items.

7. End the meeting with a review of action items and assignments (F. D. Butterfoss, 2007).

Coalition Activities Should Affect Multiple Levels

CCAT suggests that implementation activities employed by coalitions must affect not just individual-level behaviors, but rather multiple levels in order to create meaningful change in health and social outcomes (F. D. Butterfoss, 2007). "Fundamental societal transformation,

including racial equity and social and economic justice, requires changes in laws, policies, regulations, and practices, including closing loopholes that perpetuate inequities" (Tom Wolff et al., 2017).   Collaboratives should spend time developing advocacy and political skills, and develop the relationships with policy makers and advocacy groups necessary to change policies.

Evaluation of Coalitions

Concordant to implementation strategies, coalition changes and outcomes should be measured at all levels. Achieving outcomes through action requires the coalition to be able to measure its successes (or failures), and the measurement of that success allow the coalition to publicize its actions through annual reports. However, coalition evaluation is complex and coalition activities do not lend themselves well to typical evaluation designs. Coalition goals are often broad; change often occurs slowly; change may occur at the organizational and policy level rather than the individual level; and coalition activities may purposefully change* (Wallerstein, Polascek, & Maltrud, 2002).   For these reasons, the effectiveness of coalitions at an individual is often hard to discern, and from a theoretical level, it is difficult to say for certain which models or frameworks for coalition building are effective—if there are any. The challenge in evaluating coalitions may in fact be one of the reasons Collective Impact was so quick to take hold in the minds of organizations and governments. Moreover, when governments and organizations began implementing the Collective Impact, it was extremely difficult to tell if these coalitions were successful—that is, if these coalitions were more successful than if they had used a different type of coalition framework.

Wallerstein et al. describe several types of coalition evaluation:

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* Some of these same challenges in coalition evaluation can also be found in the challenges experienced in the integration of healthcare and social services.

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research into the effectiveness of coalitions in their internal functioning and dynamics;

the effectiveness of coalitions to promote outcomes, whether they are health promotion or

community capacity and empowerment outcomes; participatory and empowerment

evaluation principles and methodologies; community and neighborhood indicator

development; and evaluation theory that supports an alternative scientific paradigm of

inquiry. (2002)

In much my DELTA project work, I focus on the internal function and dynamics of

coalitions, but certainly all of types of coalition evaluations noted above are linked to one

another.

Governance, Organizational Behavior, Group Work

There is extensive literature on the topics of governance of common goods, systems

thinking, leadership, and group processes; yet in this section, I discuss only some of the more

prominent works from Ostrom, Senge, Heifetz, Hackman, which are particularly applicable to

what I observed in the WHI.

Ostrom's Governing the Commons

Ostrom's (1990) work *Governing the Commons: The Evolution of Institutions* deals with

issues of collectively managing scarce resources in the absence of hierarchical or formal

government. Her work is relevant to coalitions as it deals with how different actors can come

together and self-govern to manage common goods. These common goods may be financial

resources, collective efforts to produce policy changes, as well as the coalition itself—the

network of individuals and organizations as a vehicle for change*. The resources that need to be

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* This idea derives from the article written by Cochrane, but does not directly cite his examples provided in the article (Cochran, 1999).

managed in a healthcare and social service coalition can be viewed as the flow of money into a community to provide services to the coalition's target population and the time that providers dedicate to the coalition. In essence, that is the theory behind ACOs and Accountable Health Communities—providers and communities should be given resources to manage a population and should self-organize to best utilize those resources.

Ostrom's model states in order to govern common resources, that individuals may join together to create a set of rules and enforce those rules in an organization that is neither fully private nor fully public (Ostrom, 1990).   She defines the concept of common pool resources, resources which can be preserved through the collective management of those resources. Ostrom describes 8 key principles to governing a common:

- Define clear group boundaries.

- Match governance rules of common goods to local context.

- Those most affected by the rules should be able to participate in modifying the rules

- The behaviors of group members should be monitored by group members. Group members are accountable to one another.

- Sanctions for violation of rules should be graduated.

- Conflict resolution should be easily accessible, and low cost.

- The authority of the group is recognized by their own institutions.

- There are nested levels of organization by which the rules are defined, monitored and enforced (Ostrom, 1990).

In some ways, this is exactly what healthcare coalitions are trying to do. They are seeking to change the rules and operations by which they finance and provide services to individuals in order to provide a common good –improved health for a population. It that sense,

we can learn from the principles espoused by Ostrom and apply them to coalition work. In fact, Fisher and Corrigan (2014) suggest in their Accountable Health Communities article the marriage of Ostrom's principles of governance with the conditions outlined by Collective Impact model. Applied to health policy, this concept of governing the commons is inherent the following policy proposal:

> States also may consider promoting community- or provider-level budgeting or shared-savings approaches. For example, community health budgets could include a blend of public health, Medicaid, and social services funds. Within those budgets, a population-level shared-savings model could distribute savings to entities that contribute to population health improvements.(McGinnis, Crawford, & Somers, 2014)

If communities are in control of their budgets, they can decide how to coordinate services in their budgets, who how rules should be tailored to match the local context, how conflicts should be resolved, and how members are accountable to one another.

Senge's The Fifth Discipline

Peter Senge's *The Fifth Discipline* (2006) describes the challenges organizations face in becoming a learning organization. Coalitions are distinct from organizations; however, Senge's systems approach to organizations is relevant to many coalitions. Senge describes the five interrelated disciplines which need to be practiced in a learning organization: personal mastery, mental models, shared vision, team learning, and systems thinking (the fifth discipline). Although all of these disciplines are relevant to coalitions, the discipline of *mental models* is particularly important to the integration of health and social services, two sectors which often have very different mental models of service provision.

Mental models are deeply ingrained models, assumptions , generalizations of how we understand the world, and how we take action (Senge, 2006). Those mental models that are most dangerous are those that are the most widely shared, and not made explicit (Senge, 2006). The are many mental models that differ in the healthcare and social services sectors: the definition of problems (i.e. individual, largely physical problems as opposed to social problems which may be mental, physical, or spiritual); the way in which problems are solved; the tools to address problems (e.g. medical technology in the healthcare sector and the provision of food and housing in the social service sector); the responsibilities of the provider; and the responsibilities of the patient. These are just a few of the many different mental models, which influence efforts to integrate healthcare and social services. By eliciting mental models, facilitators can foster team learning environments in which participants view one another as colleagues and can suspend their own assumptions (Senge, 2006).

Heifetz' Theory of Leadership

Heifetz' approach to problems and leadership is informative to coalitions. Particularly informative are his notions that authority is different from the exercise of leadership and that leadership can be exercised by any coalition member. Also germane to coalition work is the previously-discussed concept of the *holding environment* which must be created in any coalition. These concepts, as well other key constructs are described below.

Adaptive Challenges, Leadership, and Authority

Heifetz makes a distinction between adaptive and technical challenges. *Adaptive challenges* are those where there is a gap between the values people stand for and the reality they face, and there is no known or agreed-upon solution to address this gap (R. A. Heifetz, 1994). Adaptive challenges require a "change in values, beliefs, or behaviors" (Heifetz, 1994, pg. 22).

Technical challenges are those where there is a known solution to the problem, and that solution is attainable through established processes (R. A. Heifetz, 1994). Heifetz then uses this to define *leadership* as the process by which individuals encourage communities to face their adaptive challenges (R. A. Heifetz, 1994). From this point of view anyone can exercise leadership from any position in an organization or in society (R. A. Heifetz, 1994).

Heifetz (1994) is careful to make the distinction between authority and leadership: *authority* connotes power within a system, both formal and informal, in exchange protection, direction and order. Those with positions of authority, may or may not exercise leadership as it is previously defined, depending on if they encourage communities to face their adaptive challenges. Often the exercise of leadership requires a person to go beyond the scope of their formal authority, such as raising unexpected or hard questions (R. A. Heifetz, 1994). One constraint that people in positions of authority often face is the expectation to provide direction—in other words, they are expected to have the answers to adaptive challenges which require a change in values or behaviors from the community. Those in positions of authority must, if they are to exercise leadership, find some way to give the work back to the members of their community (R. A. Heifetz, 1994), keeping in mind the *holding environment,* the level of *disequilibrium,* potential losses to the group, and the group's response to failures—key concepts which are described below.

Holding Environment, Disequilibrium, Losses, and Failure

As described above, the *holding environment* is the set of relationships and social systems that keep people engaged with one another (R. A. Heifetz, 1994). These can include personal relationships, agreed-upon rules or norms, common values, or past experiences. If the holding environment is not strong enough, the stresses created by addressing adaptive challenges may

cause a group to break apart. For that reason, it is important for group members to monitor the

level of disequilibrium—the level of conflict and tension within a group (R. A. Heifetz, 1994).

The group as a whole should not be too comfortable—a state in which people will not be

inclined to change—or too overwhelmed—a state in which people will disengage from work.

In an adaptive challenge, the reason that tension is created, is that different people and

groups face potential losses if the status quo is changed (Heifetz & Linsky, 2002). Types of

losses include loss of money, power, status, familiarity, or even worldview.   Helping others

cope with these losses is the process of maintaining the holding environment and addressing the

adaptive challenge. Heifetz also notes the importance of embracing failures, of viewing adaptive

work in an experimental mindset (R. Heifetz, Grashow, & Linsky, 2009).

Applying Heifetz' Concepts to Coalitions

In coalitions, it is important to engage both people in positions of formal authority,

informal authority, and those without authority. It is important to understand the different

factions involved in the challenge that the coalition is attempting to address.   In order to do this,

Heifetz suggests that a faction map can be created which notes the relevant groups, their values

and potential losses that keep them in their current position. Coalitions, may simply recreate the

same power structures underlying the issues they are hoping to solve. This is a concept which

Heifetz describes as *mirroring*, where social systems are recreated in different contexts as a

result of familiar behaviors and power structures (R. A. Heifetz, 1994).   For the coalitions to

address complex challenges, members of the coalition must operate beyond the scope of their

authority. This may include one member explicitly naming the monetary losses that her or

another organization faces if the coalition mission is successful. This may create tensions, and if

the *holding environment* is not strong enough, the coalition may not be able to succeed. It is

important to view coalition work with an experimental mind-set. If failures are not openly

discussed, then underlying causes to the problems that the coalition members seek to address will

remain below the surface.

Hackman's Process Gains and Group Effectiveness

The theory behind coalitions is that more can be achieved by working together than

working separately. The concept of *process gains* describes the conditions under which this

theory is accurate and when it is not accurate. It is easiest to think of process gains as synergistic

processes that could not have resulted without the interactions in a group. A group's

effectiveness is therefore significantly moderated by its ability to minimize process losses and

maximize process gains (Hackman & Morris, 1975). The main dimensions of group

effectiveness, Hackman describes, are effort, knowledge and skill, and performance strategies

(also described as group norms) (Hackman, 1976).

Skill level of group members must be at the right level of heterogeneity for a group to

result in process gains. If it is too homogenous amongst the group, then the benefits of group

work are lost, yet if it is too diverse, there is not enough common ground for the group to come

together (Hackman, 1976). In addition to a variety of task-related skills, individuals must have

right level of interpersonal skills to work through "conflictual or competitive relationship[s] with

one another (Hackman, 1976, p. 18). Coalitions often have organizations who have conflicting

and competitive relationships outside of the coalition, so interpersonal skills are key to

overcoming those forces drawing the group apart—those forces which may disrupt the

coalition's holding environment. Hackman continues that group norms are important for

completing tasks. If group norms are appropriate to a given task, then the codified norms

facilitate an efficient process by which almost all of the group time is spent on completing the

task (rather than discussing norms). However, if the norms are not appropriate to the task, then it is worthwhile to discuss group norms—or norms strategy; however, groups rarely self-examine and the impetus for change often must come from outside (Hackman, 1976).

<div align="center">***</div>

The topics reviewed in the analytical platform—local, state and national context of healthcare; the integration of healthcare and social services; and coalition and organizational behavior literature—helped to shape my DELTA guiding questions and activities, as well as to provide me a foundation on which I can generalize the results from my DELTA activities.

II.   DELTA Guiding Questions, Activities, and Methods

A.   Guiding Questions

My DELTA project took place from July 2016-March 2017, when I was employed by CHRT as a healthcare analyst*.   During this time period, I used the following questions to guide my activities:

1. What are the implications of the WHI's alignment with and departures from Collective Impact and other coalition models?

2. What are the specific opportunities and challenges that coalitions seeking to integrate healthcare and social services face that individual organizations do not?

Contained within each question were several sub-questions.

1. What are the implications of the WHI's alignment with and departures from Collective Impact and other coalition models?
    - How does these alignments and departures influence the effectiveness of the WHI?
    - How is the observed coalition similar to and distinct from other coalition theories?
    - How do funding, politics, and power impact these observations?
    - Based on Collective Impact and other coalition models, what changes could help the WHI be more effective?

2. What are the specific opportunities and challenges that coalitions seeking to integrate healthcare and social services face that individual organizations do not?

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* Though my DELTA activities were time bound, my employment with CHRT continued after my DELTA project and dissertation were completed.

- What benefits can coalitions provide their member organizations that seek to integrate healthcare and social services?

- What are the structures and processes that coalitions can use to effectively integrate healthcare and social services?

- What are the political, cultural, and systemic challenges involved in efforts to integrate healthcare and social services?

- How do existing theoretical frameworks, power structures, and a focus on sustainable financing influence what is an acceptable proposed model of a community-driven health care solution and how it's effectiveness should be measured?

The activities in in my DELTA project through which I sought to answer these questions could be thought of in two overlapping categories: 1) Designing the SIM in Washtenaw and Livingston counties, a process in which I worked to convene community members to design interventions, workflows, and infrastructure to integrate healthcare and social services; and 2) A WHI process evaluation in which I conducted in-depth interviews with WHI members, reviewed previous survey tools, and created a visualization of WHI membership. A timeline of my DELTA Activities is shown on the following page in Figure 1.

	Activities	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	17-Jan	17-Feb	17-Mar
SIM Design Activities	Informational Interviews		■	■	■					
	Case Manager Surveys				■	■				
	Focus Groups					■	■	■	■	
	Small Groups						■	■	■	■
	Faction Mapping								■	■
	Financial Impact Estimation							■	■	■
	Clarifying Assumptions							■	■	■
	Budgeting							■	■	■
WHI Process Evaluation.	Interview Guide Development	■	■	■						
	IDIs with WHI Members				■	■	■	■		
	Member Survey Review	■	■				■	■	■	
	Member Mapping							■	■	■

Figure 1. Timeline of DELTA Activities

Participation and Observation of Meetings and Meeting Preparation

Throughout these activities, I was both a participant and an observer. As a participant, I worked to set agendas, develop meeting materials, facilitate meeting discussions, take notes during meetings, send out meeting summaries, and follow-up on action-steps produced. When one of my colleagues went on maternity leave in October 2016, I took responsibility for preparing WHI Steering Committee meetings—working with the CHRT executive director and WHI co-chairs to set agendas, working with stakeholders to prepare meeting materials, and assuring that the meeting went smoothly. When a second colleague went on maternity leave in November 2016, I, alongside another colleague, took a large part of the responsibility for

coordinating the SIM Work Group and four subcommittees associated with the SIM: the SIM

Intervention Subcommittee, the SIM Data/IT Subcommittee the SIM PCMH Subcommittee; and

the CHNA Subcommittee. In total, this was about seven multi-stakeholder meetings a month.

See Appendix I for a diagram on SIM governance structure.

During my participation, I also tried to be an observer. I tried to step outside of my role

in the backbone organization, into the role of coalition observer. I tried to view, as Heifetz says,

both the dance floor and the balcony. I used my dissertation as a tool to reflect on WHI as whole,

and to reflect on the agenda setting, meeting facilitation, and meeting follow-up processes. In

this step, I tried specifically to integrate the answers to question 1 in order to answer question 2:

What are the specific opportunities and challenges that coalitions seeking to integrate healthcare

and social services face that individual organizations do not?

As a participant, I observed more about how coalitions operated than I would have

through traditional, positivist research methods. From my perspective, science is a social

activity, "an activity that involves considerable judgment, regardless of the methods employed"

(House, 1994, p. 19). To that end, I paid specific attention to power dynamics and I engaged in

self-reflection throughout: two components of CBPR (B. A. Israel et al., 1998). In some sense,

the description of the SIM design activities below is an account of my cycles of participation,

reflection, and participation informed by reflection. The SIM design described below may also

serve as a compilation of tools that coalitions or groups could use when planning the integration

healthcare and social services.

Informational Interviews

I, along with my colleagues, conducted 12 different interviews with organizations in Washtenaw and Livingston County who serve individuals in the potential target populations. From those interviews, 25 different direct-service programs and 2 care provider coordination programs were identified. The purpose of these interviews was to: 1) understand the existing ways in which healthcare and social services work with one another as well as any programs working on frequent ED use; 2) to identify gaps in services and common service challenges and 3) identify opportunities for SIM intervention.   Though 12 informational interviews are certainly not sufficient to understand all the work in two counties, it does provide a starting point for problem identification and intervention design.

Survey of Care and Case Managers

As a follow-up to the informational interviews, we conducted an online survey of care and case managers in Washtenaw and Livingston Counties. *Care managers* are located primarily at PCMHs throughout the region. Their primary responsibilities are to help patients navigate medical services, and make sure they can follow-up with medical appointments. In the region, there are also *case managers*, who a mostly located at social service organizations within the county. Though they have overlapping responsibility with care managers, their focus is more general, helping people with both medical and non-medical needs. We designed the survey understand 1) where care and case managers receive referrals from; 2) service gaps in the region from the care and case managers' perspectives; and 3) what the requirements to receive services at care and case managers' institutions. counties. The survey was emailed through Qualtrics to three separate email distribution lists which many care and case managers use in the region.

Ninety-five individuals from 44 distinct organizations fully completed the survey questions. See Appendix II for the survey questions.

Focus Groups

As a part of the SIM Intervention development, we conducted six focus groups with community partners. The focus groups were used gain a deeper understanding of the priorities of the target population and the value of the proposed intervention to the target population. Community partners assisted with designing, recruiting for, conducting, and analyzing focus groups with their clients or constituents. These partners included Washtenaw County Public Health, Livingston Department of Public Health, WCCMH, Livingston County Community Mental Health, Avalon Housing, Catholic Charities, Key Development Center, New West Willow Neighborhood Association, and Park Ridge Community Center. The focus groups were co-facilitated by staff from community partners and staff from CHRT. Focus group sizes ranged from 7-11, with a total of 53 participants. Each focus group was recorded, and focus group summaries were created for each group. The summaries were then used to identify common themes, including the priorities of the target population, as well as the value that the SIM intervention could provide to these populations. Participants were given a $25 gift card for their participation in focus groups. See Appendix III for the focus group guide.

Small Groups

The SIM intervention subcommittee, which oversaw the process for designing the SIM intervention, consisted of 52 people. At any one meeting, no more than 30 attended in person, with about 5-10 more on the phone. The subcommittee met twice a month for an hour. With a group of this size, it was difficult to run a meeting that meets the principles highlighted in the Analytical Platform. Namely, it was challenging to involve many people in the discussion, to

ensure everyone understood what is going on, to assign action items, to record and revisit

unfinished discussions, and to stay on time. One solution we found was to hold smaller meetings

with voluntary subgroups to address unfinished conversations and have in-depth conversations

that were not happening at the larger meetings. These subgroups then brought proposals back to

the larger group for discussion, approval, and reintegration into the larger intervention design.

These small groups were effective at moving the intervention design along, although they were

1) difficult to schedule and 2) self-selecting (only those that had time or volunteered

participated). This may have resulted in causing those who were not involved in the subgroups

to disengage.

Faction Mapping

Modeled after Heifetz' framework, I created a faction map: a document with relevant

groups, their values, potential gains from a change in the system, and the potential losses that

they face which keep them in their current position. Losses in this case, may be financial losses,

but also losses in power, prestige, familiarity, and worldview. The purpose of doing so is to help

uncover hidden perspectives or barriers to helping a coalition address its adaptive challenge. In

this case, I hoped to uncover perspectives that might be inhibiting the integration of healthcare

and social services. I checked this faction map with selected WHI members, to gather different

perspectives on the different values, potential gains, and potential losses of different factions. See

Appendix IV for the faction map.

Financial Impact Estimation

Estimating the financial impact of the intervention is another method of seeking to make

the hidden visible. Understanding the financial implications of an intervention among different

stakeholders may be key to understanding the positions of those stakeholders. Doing this

requires stakeholders to be open and honest about the costs of their services, as well as the reimbursement they receive for those services—which, due to the negotiation process with payers, health systems are reluctant to do. Further complicating matters, the financial models of health system and social service systems are quite different. Since many social services are grant-driven rather service driven, the costs of their services usually are tabulated to be exactly what they are reimbursed for those services, making it difficult to understand how costs might change as the number of visits changes. Just getting all of the data necessary in order to appropriately compare the financial impact of an intervention on all these different services is quite a tall order. It is another step to actually have a conversation about these data, and how that affects the positions of each of the stakeholders. It is yet another step to have conversation that acknowledges winners and losers in an intervention, and to make financial adjustments accordingly. I tried to obtain data on healthcare costs per visit, revenues per visits, and average number of visits, for patients with 5 or more ED visits in the previous 12 month in Washtenaw and Livingston counties. Specifically, I looked for facility costs, and provider costs, but did not include copays, ambulance costs.   I tried to obtain data from health systems related to ED visits, inpatient visits, and primary care visits, but have yet to get complete estimates. I obtained data from a social service organization on case management visits and am working on getting data a mental health agency on mental health visits. After obtaining all the data, I will then estimate how finances would change if ED visits and admissions were reduced by some percentage while primary care, case management, and mental health visits were increased.   A template of this estimation tool is included in Appendix V, with estimates based on publicly available data and articles (as I was asked by the health system not to share their data). At the time of this writing,

we have not yet had a conversation about the winners and losers if the SIM is successful, though it is acknowledged that health systems will likely lose income, at least in the short term.

Clarifying Assumptions

In line with Senge's concept of mental models, I thought it was important to help those designing the SIM intervention clarify their assumptions. To do this, I created a document that outlined each step of the proposed intervention model (See Appendices VI and VII). In each step, there was a description of the intervention model, the explicit assumption behind the description, and a list of questions to answer based on the assumptions and description. This document was first circulated through CHRT, then to the SIM Work-Group co-chairs, and will be given to a small group to discuss in May 2017. The most important part of this work will be to ensure that people agree with the descriptions and assumptions. The document seeks to clarify mental models, test our assumptions against reality, and adapt the SIM intervention design and work flow as new perspectives are uncovered.

Budgeting

The SIM implementation funding for Washtenaw and Livingston counties was approximately 1.3 million dollars per year (with an additional 0.2 million dollars to CHRT for backbone services). The money came to the WHI, a collaborative of multiple stakeholders. The process for distributing that money across that community was not clear. We used a decision-matrix to develop a process for who should make what decisions. From there, CHRT developed a budget, which was first shared with the SIM Work Group co-chairs, and then the WHI Finance Committee. Next, we presented the draft budget to the SIM Work Group, engaged in conversation around budget distributions, and reviewed the budget. Finally, we had to select who would receive the money in the budget. This process is still underway at the time of this

dissertation writing, but it is expected that funding will be allocated based on an application process that takes into account geographic location, organizational fit, and the needs of the target population.

C.   WHI Process Evaluation

In-Depth Interviews with WHI Members

From October 2016 through January 2017, I completed 14 semi-structured in-depth interviews (IDIs). IDIs were conducted with WHI steering committee members, work group chairs, work group members, project members, previously involved stakeholders, and backbone staff. The IDI interview guide (see Appendix VIII) questions aligned with the key elements of Collective Impact: common agenda, shared measurement, continuous communication, mutually reinforcing activities, and backbone organizations. The WHI member survey results (discussed below) also informed the interview questions.

Thirteen of the IDIs were recorded (one participant did not wish to be recorded). Interview summaries were created after each interview. I listened to each interview recording and used the summaries and IDI notes to select key quotations and key themes from each interview. I then used the summaries, along with notes, quotations and identified themes from individual interviews to identify common themes across interviews. These themes were used to compare the WHI with the Collective Impact model, as well as with other coalition theories. Additionally, interview findings were compared to the other methods in WHI process evaluation to create a more holistic picture of the coalition. IRB approval for the completion of the interviews was obtained from the Harvard Longwood Medical Area IRB.

The WHI member survey was completed in February 2016, before I began my DELTA project. The survey questions focused on four areas: communication, effectiveness, coordination, and collaboration. The survey was administered electronically through Qualtrics. It was sent to 275 individuals on WHI's stakeholders list. Eighty-nine (32%) individuals responded to the survey by the time it closed two weeks after it was sent out. I used the results of the member survey in three ways: 1) to inform the design of the IDI question guide; 2) to help answer my guiding questions and 3) to understand the results and recommendations for change the members of the WHI steering committee had already seen, so as to provide additional information and context for what I heard in the IDIs as well as to shape the recommendations that I will make in the results section. See Appendix IX for the survey questions and results, which were presented to the WHI Steering Committee in June 2016.

During the IDIs, some of the participants had brought up the question of "What does it mean to be a WHI member?" The suggestion was that the WHI included many organizations as members, who do not participate, or who participate very infrequently. The WHI reports that it has over 80 member organizations. In order to be able to assess member participation, I decided to create member maps at an organizational level. By reviewing meeting attendance from Steering Committee, Work Groups, and Stakeholder meetings in 2016, I was able to ascertain which organizations attended meetings together. In these maps, node size of the organization represented the number of meetings and individuals at each meeting of a given organization. The thickness of the edges between the nodes represented the relationship between organizations—or the number times that individuals from each organization had been at the same

meeting (If more than one individual from the same organization was in attendance at a meeting, that organization was counted twice at that particular meeting). Only in-person attendance was included, as it was thought in-person attendance was a better measure of participation and relationship development between organizations. Notably, just because organizations had a representative at a particular meeting does not necessarily mean that person spoke at the meeting. Additionally, people on the phone are not included in the map, whose participation and engagement varies depending on person and the meeting.

<div align="center">***</div>

The SIM and the WHI pre-dated my DELTA, and will continue on now that my DELTA is finished. The Guiding Questions, Activities and Methods described above are as a product of the work required when designing the SIM in Washtenaw and Livingston counties as well as building on the existing WHI evaluation efforts. I will continue working on these activities after the completion of my DELTA. The results below are simply a reflection of my learnings from these activities to-date, learnings which I expect to continue even though my written dissertation is complete.

III.   Results

The results are loosely organized around the guiding questions. Sections A & B address the implications of WHI's alignment and departures with the *Common Agenda* and *Backbone* attributes of the Collective Impact Model. Sections C & D joins the Collective Impact concepts of *Continuous Communication*, *Shared Measurement*, and *Mutual Reinforcing Activities* with concepts from other coalition models. Section E discusses Community Engagement, which is distinctly lacking from the original conceptualization of Collective Impact. Finally, Section F describes the WHI's experiences as a coalition attempting to integrate healthcare and social services. The headings of each section in the results derive from themes that emerged in the IDIs. In contextualizing and analyzing interview themes, I seek to integrate those findings with the results from the additional methods described above in the evaluation of WHI and in the implementation of SIM, as well as with other concepts from the analytic platform. After describing the themes and linked analysis, I then describe some conclusions to more concretely answer the guiding questions.

A.   The WHI's Most Salient Agenda is Promoting Community Connections

The first attribute in Collective Impact is to have a *common agenda*. From the interviews, it was clear that the WHI did have a common agenda when it began in 2010.   The following quotation from a work group chair was representative of what most thought about the WHI's purpose when it began: "*I think originally [the purpose] was clear when it started…prepare the county for the implementation of the ACA.*" In addition to have a common agenda when the WHI formed in 2010, the WHI also demonstrated Wolff's dimension of *community readiness.* The health provider community was concerned that it might not have enough primary care physicians to meet the increased demand for services as a result of increased people with insurance after the

ACA. This coalition took into account the history of failed coalitions in the community—that the hospitals were not involved at a CEO level or that they were too involved without involving those outside the hospital. This coalition was able to gain traction because MM and SJMHS were not intense competitors—MM is an academic hospital and SJMHS is a community hospital—and that both hospitals were on a sound financial footing. The WHI had the support and involvement of both hospital CEOs when it began in 2011.

After the implementation of the ACA in 2014; however, the WHI's purpose became less clear to its members. Again, almost every person I interviewed described the WHI's agenda as evolving, perhaps having more than one agenda rather than a single common agenda. In contrast to the Collective Impact model, Wolff (2016) says that a common agenda may not be possible or even desirable in coalitions where members have conflicting self-interests. The WHI—which has large healthcare systems, small medical practices, social service organizations big and small, as well as payers and government agencies–may have a number of conflicting self-interests that inhibit its ability to have one common agenda. Nevertheless, this does not prohibit the WHI from working towards several objectives, so long as the time and resources are available to work on these different agendas. The most salient agenda cited by interviewees was promoting connections across organizations providing services for the low-income in Washtenaw County. However, there were two other often-cited agendas: the original mission of improving healthcare access for the uninsured and low-income populations in Washtenaw County; and the SIM.

The most-cited purpose of WHI was to improve the coordination of healthcare services

and networking with other organizations in the community. In the member survey, 82% of

respondents from the survey say that WHI has helped organizations "better understanding of the

roles of member organizations within Washtenaw County." This was also reflected in the

following quotation:

> *A big piece of the WHI is networking…setting up formal and informal alliances between*
>
> *groups. It has done a good job of pulling together the health systems in a way they were*
>
> *not before. And in some of the groups, it does a good job of pulling together people in*
>
> *across areas. There is a lot of value in networking: Do you know who to call with you*
>
> *have an issue? So you can capitalize on those networks outside of meetings.* -Work
>
> Group Chair

This networking process may allow the WHI members to create mutually reinforcing

activities: a key component of the Collective Impact model. Throughout the interviews, specific

projects came up that demonstrated an overarching planning process by which the activities of

separate organizations coordinated to address a community-wide problem:

- *The Opioid Project:* The project combines people from health systems' ED and mental

  health providers; substance use programs; other social service agencies; the sheriff's

  department; and the county department of public health. This cross-stakeholder group

  works together to educate the community and provide resources to stem the opioid

  epidemic.

- *Tailored Mental Health Management Support for Primary Care (TaMMS)*: The TaMMs project integrates mental health services into four safety-net primary care settings across different health systems in Washtenaw County. The evaluation of the program has shown significant cost and health benefits. To sustain this project the TaMMS team and MMCOs are in the process of discussing reimbursement codes for TaMMS-type care management.

- *The Acute Dental Project:* The Acute Dental program was able to provide free dental care to patients referred from EDs, whose primary reason for visiting the ED was a dental problem. Again, this project worked across both health systems in conjunction with the Community Dental Clinic and the WHP. Part of the success of this project was not only the people they were able to treat, but the lessons they learned across the system about how much follow-up is necessary to get people to attend dental appointments.

Although there were certainly challenges with these projects, they were described as successful because of their reach across multiple organizations, as well as their ability to change how the organizations involved were operating to fill gaps in the community—an outcome which is not evident in all of WHI's projects.

While many in the interview participants and the member survey did say that the WHI improved networking, only 34% of those surveyed believed that the WHI "reduced service duplication." Part of this perception may be due to how the WHI decides to undertake new projects.

> *When the WHI first started, we had to do a Lean [manufacturing] process, and do an analysis and come up with some projects. And overall, I think that led to some really good projects…Going back to that process would be good.* -Work Group Chair

A Lean manufacturing process has embedded within it, a root cause analysis which examines a problem in detail, and whether or not it should be taken on. Returning to this approach to decision-making may be helpful for helping the WHI decide what is inside its scope of work, and what is not.

Another possible explanation for the member survey results above are that WHI members did not perceive service duplication to be a problem in the first place. In my observation of the discussion of the problems facing healthcare, the idea that service duplication is a problem is generally accepted at the state government level, by many people in Washtenaw and Livingston counties, as well as in the Collective Impact model. This problem is also at the heart of the design of the SIM model (Appendix VI). There is an idea that people have many care and case managers who are not coordinating with one another, and that if they can talk to one another, they can figure out how to better serve their patients and clients. This even emerged as a theme from the SIM focus groups as well. This may be true, but the root cause of the service duplication may be the gaps in services, rather than the fact the care and case managers are not coordinating with one another. For example, due to a lack of affordable housing, there are numerous eligibility and application requirements to determine who is "worthy" of the scarce housing. These requirements make accessing affordable housing even more difficult and complex—creating a need for case managers to help people navigate the system. If a person is unhappy with one case manager's assistance with finding housing, they may then go to a second or third case manager for assistance. In this case, service duplication is certainly happening, but the root of that duplication is a gap in affordable housing. Care coordination may help streamline access to existing resources for patients, where knowledge of these resources is absent. However, it is not going to solve the gaps in service that exist in the county unless organizations not only

coordinate their activities, but some actually change what they are doing to fill in those gaps—a flexibility which many grant-funded organizations may not have. This line of thinking is exemplified in the following quote from a Work Group member: "*So, this is the challenge with the Collective Impact model. You do all this work, but is it changing what we're doing? Are we working more collaboratively together? I don't think I've seen a change in service delivery as a result of WHI.*"

Improving healthcare access for the uninsured and low-income populations in Washtenaw County

Improving healthcare access for the uninsured and low-income population in Washtenaw county—the original purpose of the WHI—was also discussed as one of the agendas of the WHI, although it came across less saliently than the theme of coordination and networking. After the ACA was implemented in 2014, the WHI went through a strategic planning process to determine if it should continue, and what it should focus on if it continued. The projects the WHI has taken on since 2014, projects which are much broader than the original issues of healthcare access for the uninsured and newly insured under the ACA. There were differences of opinion over whether the WHI should be expanding its focus to the coordination of services where there was not a specific focus on low-income populations. This potential change in the WHI's mission was identified both in interviews as well as in the member survey.

The SIM

A final possible agenda of the WHI was the SIM. The SIM represents more money than the WHI has ever had before. At approximately $1.5 million a year, its contribution to the WHI more than quadruples its previous operating budget, even when previous in-kind support is

included. Many people interviewed questioned whether or not the SIM would subsume the

WHI.

B.   The WHI's Strengths and Weakness Reflect Those of the Backbone Organization

CHRT is the WHI's *backbone organization,* another key component of the Collective

Impact model. The strengths of the WHI are primarily on data analysis and reporting. As an

organization, CHRT's focus has been to translate data and health services research into policy

relevant briefs to inform decision-making at an organizational, legislative, and policy level. The

fact that much of the work of the WHI gets completed by CHRT staff is one of the reasons why

the strengths of the WHI mirror that of CHRT. The following quotation by one of the CHRT

staff members describes the process by which one of the WHI's assessments came to be

completed by CHRT staff members:

> *I wasn't really here when it started…from my understanding, a lot of the analysis, there*
> *wasn't anyone who wanted to or had time to do that portion. It was work that CHRT*
> *staff is good at and has done, so pulling public data sets and integrating that data into*
> *the assessment, that's something we do in all our issue briefs too. -CHRT Staff*

This excerpt identifies the fact that it is often challenging to solicit volunteers for

completing WHI work, and thus, the role falls to CHRT staff. The WHI is mostly CEOs at

steering committee level—this brings funding and powerful people. However, it does not bring

people who have a lot of time on their hands, and generally does not bring people who have

experience working with low-income individuals.   Thus, when it comes time to carry out actions

steps or follow-up on unfinished conversations from the steering committee meetings, unless the

action items are to help with funding or to make a quick personal connection, the responsibility

is left to CHRT staff. This culture also permeates to the work group level, where individuals are similarly pressed for time. The fact that this work is likely to fall on CHRT staff may also limit the type of work which the WHI undertakes—it may focus primarily on data analysis and reporting as opposed to direct service provision or community engagement. Even though CHRT staff may be doing a lot of the work behind the scenes of the WHI, CHRT staff feel, at least at the work group level, that the work is driven by members of the WHI, as opposed to CHRT staff.

The above excerpt also alludes to another parallel between CHRT and the WHI: that CHRT staff, and therefore WHI support staff, turnover frequently, and thus, there are many projects which must be passed from one staff member to another. This, in turn, may also limit the types of work the WHI can do. It is unlikely to be as successful in projects that require long-term relationship building, and more likely to be successful in short-term projects, which are not as dependent on relationships. This is perhaps an example of where the challenges in WHI mirror the challenges of the healthcare system. The projects that are undertaken by the healthcare system as well as those by efforts to integrate healthcare and social services are focused on short-term gains, because that is what they know they can be successful with. A work group co-chair from one of the health systems is quick to point out, that although this model may not be ideal, there is not likely a perfect model.

> *You're talking about trying to get people with fulltime jobs engaged and involved, so you need that organization to help keep the wheels turning. I've been impressed with how they've used it to bring in these health policy fellows to staff it and keep things organized. They [the health policy fellows] then move on, which is always a challenge in terms of turnover and loss of knowledge and momentum, but it seems like it's serving a purpose of*

providing experience to folks…So, I think you can criticize things about it, but I don't

think there's any structure that would be perfect. -Work Group Chair

As the WHI is currently structured, it may need to strike a balance of taking on projects that are familiar to the healthcare systems, which provide the majority of its funding, and taking on projects that push healthcare systems to work with and learn from the long-term outlook of many mission-driven social service organizations. However, if one of the purposes of WHI is to be a convener of organizations, a process which does rely on relationship-building, then the turnover of CHRT staff may be detrimental to this work. Those that come to the table are those with which the directors of CHRT and the WHI program manager has continuous relationships.

In addition to the challenge of turnover, relying on CHRT staff to do the work of the WHI can also be problematic when CHRT staff have other commitments to work outside of the WHI. Almost every single CHRT staff member who works to support the WHI has outside projects which have a tight deadline and are funded by an outside client. These projects often take precedence over WHI projects, whose work may be funded, but are not usually on strict deadlines. With CHRT's shifting business model, which now relies increasingly on client-driven work, the prioritization of WHI work is likely to remain a challenge. Yet, all coalitions struggle with being able to keep up with the demands of coalition due to a lack of funding and staffing. And the WHI is no different in that sense. In coalitions that have a backbone organization whose sole purpose is to provide support for a coalition, there may not be conflicting demands on staff, but there are likely other drawbacks. CHRT brings with it significant resources because of its position as separate non-profit that is housed at the University of Michigan. It also brings insight from policy makers and payers to the WHI that would not be possible without the activities that CHRT undertakes that are unrelated to the WHI.

This section describes the WHI's structures, member engagement, and communication. In this section, I found it most helpful to integrate the Collective Impact's attribute of *continuous communication* with the concepts of membership engagement and coalition structure described in the coalition and organizational behavior literature.

Revisiting the purpose of coalitions described in the analytical platform, coalitions are successful if they are able to "influence the delivery and intervention strategies among community agencies and among existing community agencies and organizations" (Wandersman et al., 2008). Key to this success is member engagement (F. D. Butterfoss, 2007; Thomas Wolff, 2001). Members must be engaged if they are to transform either themselves or the system within which they are operating. If the work is driven by the backbone organization, without member engagement, then the operational structure of a coalition is not very different than a single organization. However, with the commitment of coalition members, coalitions can influence the operations of each of its members to have greater effect than any one organization could have separately. Cultivating member engagement requires a collaborative atmosphere, the creation of an intentional *holding environment*, and alignment with purpose, goals and theory of change. Each of these requirements necessitates skills which are present in some places in the WHI, but not in all. Each WHI Committee, Work Group and project is different, and not all observations described below apply to all WHI groups. However, apart from stakeholder meetings, where the number of attendees is approximately 70 people making the meeting dynamic quite a bit

different, most of what is described below is applicable to many of the WHI meetings and groups.

Clarity in structure and communication can foster or inhibit member engagement

When asked to describe the WHI, interview participants almost universally described the actions of the steering committee, rather than the work groups or projects, or the organizations that make up those work groups and projects. This distinctly conveys that WHI members do not necessarily feel a sense of belonging to the coalition as whole. Moreover, almost no one interviewed felt they had influence over the agenda of the steering committee. The WHI Steering Committee Member Map, Figure 2 on the following page, shows that the Steering Committee centers around the two health systems, which may be why many don't necessarily feel ownership over the steering committee.

At a work group level and project level, members did feel a sense of influence over the agenda, and thus, more investment into the actions and projects at that level. Some interviewees felt that the steering committee was not responsive to its members, but rather the steering committee represented a top-drown, centralized structure dictating the direction of the WHI. This criticism is the same as one levied against the Collective Impact model in general. At 20 members, many of whom are executives or former executives, there are a lot of powerful people on the steering committee. Regardless of the steering committee's intent or process, a lack of clarity in structure can lead to this criticism.
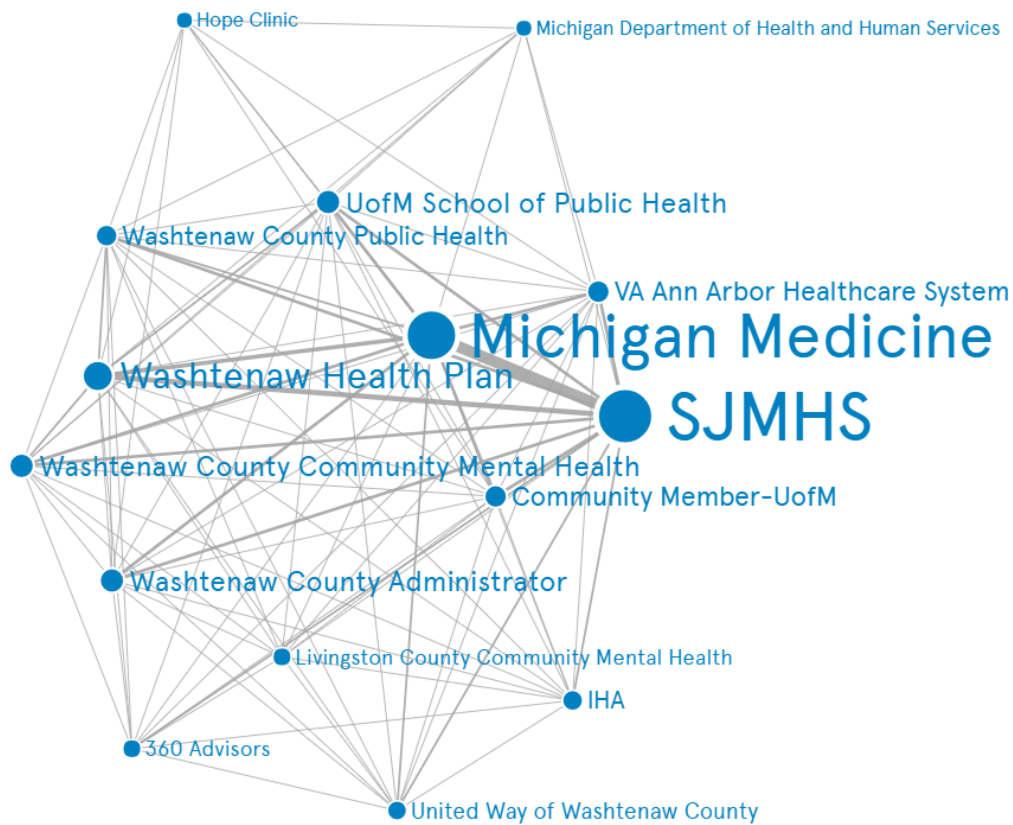
Figure 2. WHI 2016 Steering Committee Member Map

When the WHI began, there were seven steering committee members. As it has grown, though it has created more membership rules, the necessary process structure of the steering committee has not kept pace with its growth. With a 20-member committee, it is likely wise to have to have an executive group to help plan. Yet, this executive group is not formally recognized, creating an aura of inaccessibility to those not involved in the group, or in the steering committee. As Ostrom (1990) notes, the effectiveness of groups is in part driven by how visible the actions are to other group members. At the steering committee level, the actions are not easily visible to steering committee members, and the actions are nearly invisible to the rest of the WHI. At a work group level, there are not as many powerful people in the room, and

the actions are more visible to a wider variety of WHI members. Each member of the work group feels they have more influence over the direction and agenda of the work groups, thus making them more engaged in the work group.

Communications, Resource Distribution, and Control

The WHI relies heavily on electronic communications through email and newsletters, formal communication in meetings, and informal communications through CHRT staff. With the SIM, as a distributor of funding, the WHI will be called upon to make its conversations about who gets funding more public. Anyone is welcome to come to and observe SIM meetings, though the WHI's outreach to specific organizations has been largely based on its previous relationships. There have been calls to disburse the SIM funding through a fair and transparent process. One interviewees noted that *"if there are particular resources that come in, we are talking about how we share those resources."* Most conversations about resource distribution take place among a small group of people, outside of formal meetings. The WHI meetings had not previously had public documentation of meeting content available to stakeholders until I began writing meeting summaries and posting them on the WHI website. There are conversations about resource distribution at the WHI Finance Committee, but as this comment from the member survey indicates, there were no documented minutes or summary of the finance committee meetings: "*The Steering Committee and Finance Committee should have regularly published and shared minutes*." There still are no documented summaries of the WHI Finance Committee.

Those I interviewed thought that these meeting summaries were a fine start, but that the issues that WHI has around communication really are much more around making people feel involved who did not feel involved and making private conversations public. Underlying both of

those concepts is the issue of power. As Labonte (2012) notes, making private conversations public is a form of powering sharing that can be useful in coalitions. To date, it remains to be seen how much the WHI will be able to make its conversations, which are ostensibly public, more transparent. Can you have a public conversation about how WHI agendas are set? Around how SIM dollars are disbursed? Around how the SIM intervention will create winners and losers in the community? Can you implement Ostrom's (1990) governing principles to change the how healthcare and social services are financed and delivered? One of the challenges with having open conversations is the competitive nature of the healthcare world. Hospitals and payers negotiate over reimbursement rates, thus it is extremely difficult to have any real conversation about healthcare costs in the community and how resources should be distributed. I have still not been able to obtain complete cost figures for the SIM Financial Cost Estimations (Appendix V) from the health systems. What's more, in my preparation of WHI meeting materials, I saw this culture of information control permeates into other aspects of WHI, such as agenda setting and material distribution. This was also represented in the following quote:

> *There is a tension between wanting to control the agenda and the work, and being more inclusive in terms of decision making…there has to be a change in the organizational culture and there has to be less of a control by the steering committee and more of a partnership with the organizations doing the work, if it is to get beyond just a hospital-sponsored project*. -Steering Committee Member

When facilitating meetings, decisions over what topics to cover and what types of material to present at the meetings need to be made. The decisions are sometimes made by the co-chairs, but more often CHRT staff are making the decisions. In these decisions, I have often been present in conversations about how best to conduct the meeting. The question at hand is

often how best to elicit mental models from group members to facilitate dialogue by balancing focus on meeting process and meeting progress. In focusing on process, this entails bringing materials to the meeting which allow WHI members to express their opinions and get them engaged in the meeting. In focusing on progress, this entails bringing materials that allow the group to come to a decision. Often in these conversations, there is a worry that too much focus on process will slow down the momentum of the group—a concern voiced by some interview participants as well. This concern has to be balanced with the need to engage members in active discussion, a discussion which may take different turns than can be fully anticipated. Facilitation of groups, as one member notes, *"is not just about the here and now meeting facilitation. Reminding people of the aim, of mission, of outcomes, goal and that constant feedback loop, that constant line of sight issue of helping people relate what's being talked about to the next thing."* Interviewees also noted the member engagement, by connecting with people before and after meetings is a key part to facilitation.

Implicit in this balancing act of process and progress is the concept of control. In meetings with a focus on process, that are more open-ended, there is less control over what happens. In meetings that focus on progress and decision-making, those setting the agenda have more control over the meetings. The dynamics of control that payers and hospitals desire to have over the behaviors of patients are mirrored in the desire to control meetings. Whereas the focus on process and engagement is more similar to the approach that social service providers take with their clients. Focusing on process with a flexibility to what direction meetings will take, Wolff notes (2001), are some of the characteristics of collaborative leaders that help make coalitions successful. The SIM requires the WHI to distribute funding, engage many social service organizations in a collaborative planning process, and engage new stakeholders entirely.

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From the faction mapping process, I was able to understand that the public nature of these activities represent a loss of control and loss in familiarity with the WHI's operating implicit rules. I revisit this conversation when discussing community engagement below, but for now, I will say focusing more on process could help the WHI improve member engagement.

The implicit WHI norms reinforce existing power structures and causes disengagement from those without power

Another reason for the lack of member engagement through the WHI is the lack of explicit norms. As Hackman (1976) describes, implicit norms may or may not be helpful in completing a task-depending on their appropriateness to the given task. The implicit WHI meeting norms observed and described by interviews include some described above by Butterfoss (2007), as well as others not explicitly mentioned:

- Sending meeting materials and agendas in advance

- Making introductions at the beginning of every meeting

- WHI meetings generally end on time

- CHRT staff are responsible for most follow-up steps

- Most meetings now have meeting summaries

- The expectation of presenting a solution whenever a challenge is raised

- Making decisions by consensus, a process by which those opposed are required to voice their opposition

Sending out meeting materials are helpful in giving meeting attendees an opportunity to prepare in advance of the meeting; although not everyone reads all the materials. Making introductions at the beginning of meetings helps to encourage conversation from everyone and

has a minor effect of equalizing power dynamics. In meetings without introductions, those who do not know everyone at the table are less powerful than those who do. Meeting summaries allow those who missed previous meetings to catch up, to record of unfinished discussions, as well as serve as a document to hold one another responsible for following through—the these all require action on the part of meeting participants, and the creation of meeting summaries does not guarantee these meeting summaries are used appropriately.

Depending their position or perceived power status, WHI interviewees had different views on the process of making decisions by consensus. One person with experiences as a hospital executive describe the WHI decision-making process:

Most of these efforts work through consensus, so if one person, for whatever reason, is vehemently opposed to something, it stops it in its tracks….[In general, but not specific to WHI] Unless, I suppose, the individual who's advocating differently, who's the obstacle, is just perceived as off the rocker. Other than those cases where you still plow over somebody because they never agree with anything, reputation real or not. -Steering Committee Member*

This person perceived the WHI Steering Committee decision-making process to be one that gives voice to any that object. I have seen examples where this is indeed the case. When the WHI was considering if it should become a separate 501(c)3 entity, the steering committee did not proceed with this because a couple of people voiced their objections, even though many on the steering committee would have moved forward with the decision to pursue 501(c)3 status. The steering committee then brought the question to the larger stakeholder group, which overwhelming voiced objections to the WHI becoming a separate non-profit entity. This was

described by interview participants as an example when the steering committee and stakeholder meeting processes worked well.

A steering committee member who has no experience as a hospital executive presents a different view on the decision-making process:

I worry about being too deferential to the people around the table because they are the [health] system CEOs, the people with huge amounts of corporate experience, and managing large organizations. So, I tend to feel less adequate than them...I perceive myself as lower. In social hierarchy that we all carry around in our heads, I feel that I'm on a lower level than some of the top dogs. –Steering Committee Member

This quote represents, as Wolff et al. (2017) note is typical of Collective Impact efforts, how the power dynamics outside the WHI are recreated within the WHI. The norm of presenting a solution with any challenge raised also contributes to this recreation of power dynamics inside the coalition. This norm comes from a line of thinking that encourages constructive feedback. This can be beneficial when the challenge that is raised is one that is recognized and understood by most in the meeting. It can help lead to action. However, this expectation of presenting a solution also serves to mute problems which are only viewed as problems by some people or problems that don't have easy solutions. This not only discourages conflict (discussed more blow), but also avoids difficult conversations which may be the root cause of some of the issues the WHI is seeking to address. Heifetz (1994) states that those who are not in positions of authority are not expected to provide solutions to the community. The norm of raising solutions as a prerequisite to voicing problems, serves to place the restrictions of those in power on those without power. In other words, if a coalition is seeking to address common problems, if those problems are in part caused by power imbalances and a lack of awareness of those in power of

frontline knowledge, it is unlikely the WHI will confront these problems. The WHI does not

explicitly acknowledge these power dynamics, and as previous coalition literature predicts

(Himmelman, 2001; Labonte, 2012; Tom Wolff et al., 2017), the power dynamics are recreated

within the WHI itself.   One way to explain this is that those who are happy with the current

system seek to create feedback loops that stabilize the system (Senge, 2006). Raising problems

without easy solutions can destabilize a system, something that those in power generally like to

avoid.

The WHI's holding environment and facilitation do not allow for critical conversations, limiting impact

The tongue-in-cheek comment above about a person who "never agrees with anything" is

also telling of meeting dynamics. The environment of meetings is such that discourages

disagreement and conflict, as a part of the power dynamics and relationships that exist outside of

meetings. A few interviewees commented that the lack of voting in the WHI serves to silence

voices rather than serving to give voice to those who dissent.   As one steering committee

member noted: "*When I've disagreed, everybody just goes along, and I do too. I need to

maintain these relationships, because these are important partners.*"

If there is disagreement, there are enough like-minded people around the table, or enough

people who are afraid of speaking up, the opinions of those that perceive themselves as lower

power are silenced. This brings up the following questions relating to Heifetz' (1994) description

of a *holding environment*: Is it the responsibility of the WHI to create a space where people feel

comfortable speaking up? Or is it simply the fault of those individuals for not speaking up?

Only members of the WHI can decide how they wants to answer these questions. If the WHI

members feel that its holding environment is weak, that is the relationships keeping people at the

table are tenuous, then it may be wise to discourage contentious conversation so that it may keep its members at the table.   However, discouraging these conversations may also cause some members to leave the table:

> *We work with people who are have so much going on and there is such a complexity of need, and we're at the intersection of every systemic gap. So that's in our face every day. So if I go to these meetings and I feel like there's no "real talk" happening or work output feels minimalist, that can be a sense of frustration for me.* -Project Member

Moreover, if the holding environment is not strong enough to allow for disagreement, it is in the best interest of the WHI to strengthen its relationships amongst members to allow for the participation by many different members. The key balance in a productive holding environment is to create a setting in which members feel uncomfortable enough to do something about the problems they are facing, yet comfortable enough to speak up and experiment (Cormode, n.d.).

Most people interviewed had trouble describing a time when there was conflict in the WHI. Instead of conflict, the WHI was perceived as addressing common problems. One interviewee noted that the WHI does not "*have critical discussions.*" This suggests that most of the work that happens in the WHI is responses to external factors; it does not ask its members to do internal work on their own organizations. It does not ask them to change their work flows, to adjust their mental models, to recognize explicitly potential gains and losses amongst members. The only forces that it hopes to change are those of organizations who are largely absent from WHI work: government policies and payers. I noticed that representatives from payers will listen in on the phone at SIM design meetings, as well as attend the WHI stakeholder meetings; however, they rarely are contributing substantially to projects or meetings, and they do not show up as large bubbles on the WHI member maps.   In Figure 3 is a member map of 2016 SIM

meetings, where you can see five payers on or near the outside, with MM, SJMHS, and

Washtenaw County Community Mental Health showing up the largest.
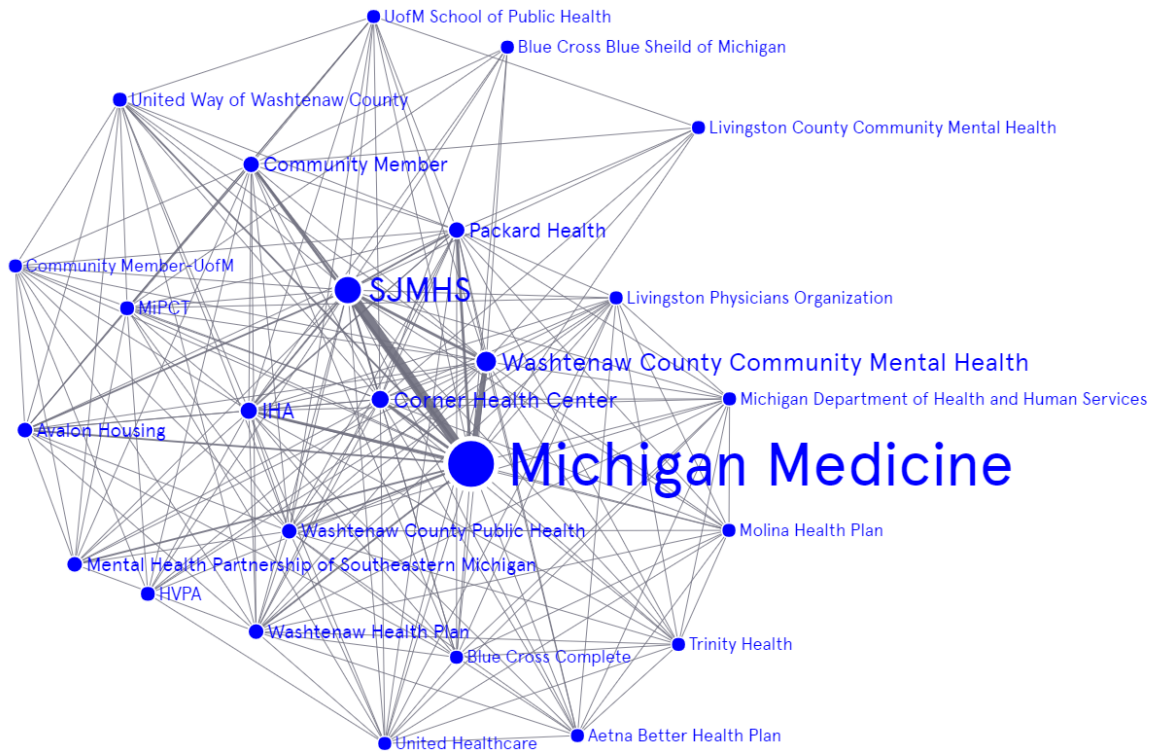
Figure 3. SIM 2016 Member Map

Interrelated with the norms around conflict and discussion is the lack of acknowledgement of

failure, which the Heifetz (1994) and Senge (2006) describe as integral to learning. One steering

committee member notes this as a problem: "*The culture of the steering committee is to avoid*

saying 'We failed.'" Having a strong holding environment, where members regard another as

colleagues, encourage everyone's participation, and can acknowledge failure can create a space

for team learning (Senge, 2006), process gains (Hackman, 1976), and effective coalitions

(Thomas Wolff, 2001).

Creating a holding environment requires skilled facilitation: "*To develop a level of intimacy and trust and comfort to have open dialogue and discernment is not something that you can just come by, without some effort.*" The following meeting behaviors are those that I have observed at some WHI meetings depending on who is facilitating the meeting, and behaviors which may help to create better holding environment, but are not implicit or explicit norms of the coalition:

- Reviewing the previous meetings' action steps and unfinished conversations

- Summarizing conversations

- Actively working to involve many people

- Asking for people to raise concerns as a positive contribution

- End each meeting with action steps

The WHI would do well to incorporate these meeting behaviors explicitly into meeting norms across the WHI. This could help to mitigate power dynamics, encourages authentic conversations, as well as provide clear roles and expectations for chairs, committee and work group members, and CHRT staff. Having explicit norms may also help to improve the effectiveness of work groups. Interviewees noted that work groups and projects vary in their effectiveness depending on the facilitation skills of the group's co-chairs.

If co-chairs are given the explicit responsibility of assigning tasks, then this may help to provide those involved in the WHI with a feeling that meetings are productive. One member notes "*There is not much [work outside of meetings]. Which is a source of frustration. If I don't have work outside of a meeting, I question its efficiency.*" The lack of work outside of meetings is also indicative coalition member engagement.

The following quote provides an example where a facilitator in one of the SIM meetings actively sought to involve different meeting members by asking members to express their concerns as a form of contributing positively to the progress of the meeting:

I'm very intimidated by this group…If they are people for whom you don't have relationships with, and you're walking in the door. You don't want be interpreted as 'I'm criticizing your work.' The reason we were able to have a dialogue in the last SIM meeting was because it was facilitated to do so by saying, "Is everyone comfortable with this?" That opened the door…to start to have that conversation about what we're all thinking but weren't saying. -WHI Project Member

Having been a participant in the meeting the interviewee was referencing, I can recall that before asking about concerns, the facilitator also summarized the conversation that had taken place prior to asking about group members' concerns. This kind of facilitation encourages open dialogue, but it can also lead to conflict, which must be managed constructively.

Facilitation of most WHI groups is done through its co-chairs, with strong assistance from CHRT staff. The benefit of this structure is that the work of facilitating and leading is divided between two people, so that one person can step up when another person needs to take a step back. Having two co-chairs can also serve as a system of support and idea generation between the co-chairs to move projects forward. However, in some sense, having two people responsible for a community issue also mirrors the problems of the healthcare and social services systems. When both co-chairs are too busy, then the collaborative work suffers. No one takes responsibility. It may be more effective for the WHI to one chair with each work group. This chair may be able to consult with an assigned member of the steering committee to provide

strategic direction on the group, but would ultimately be responsible for keeping the work of the project moving forward

D. Goals, Measurement, and Activities Should Align with a Coalition's Purpose

This section discusses the two remaining core attributes in Collective Impact are *shared measurement* and *mutually reinforcing activities.* These attributes can be identified through examination of a coalition's goals, the projects it undertakes, and how it measures itself. I combined the discussion of these attributes with the concepts from coalition literature on goals, vision, and their alignment with day-to-day activities

The WHI's overall goals

The WHI began in 2011, in response to the ACA. It was thought to be a six-month coalition. Yet, almost seven years later, it is still operating. The question has arisen, especially after the ACA was implemented in 2014, if the WHI should continue or not. The WHI decided to continue, perhaps because of its perceived success. Butterfoss (2007) notes that this is a typical coalition scenario. Most coalitions are acknowledged to be temporary, but actually disbanding is a more difficult process (F. D. Butterfoss, 2007). When coalitions have clear, measurable goals, Butterfoss (2007) states, it is easy to know when a coalition has achieved its goals and should terminate. However, when those goals are amorphous, indeterminate, it is not as easy to determine if the group should disband. Yet, as discussed in the analytic platform, it is difficult to evaluate a coalition's goals, because they are often broad and changing. Now, as the coalition has grown and evolved, the WHI has five stated goals on its website:

1. *Reduce the uninsured rate among all Washtenaw County residents age 0-64 from 8.1% to 4.3%*

2. *Increase the proportion of residents with an identified usual source of primary care from 84.3% to 90.2%*

3. *Document increased effectiveness and efficiency of programs by WHI charter signatories through alignment and coordination*

4. *Demonstrate perceived usefulness of the WHI through continued member participation by tracking the following process measures:*

   a. *Expand membership to include business and faith communities*

   b. *Number of members in the stakeholders group*

   c. *Number of members in attendance at quarterly WHI stakeholders meetings*

   d. *Number of WHI spinoff activities*

   e. *Number of hours volunteered by members*

   f. *Increase number of WHI charter organizations from 44 to 60*

5. *Ensure that every project undertaken by the WHI will have strategic and meaningful SMART* goals at the outset, an evaluation plan, and an opportunity to contribute results to the continuous learning of the WHI."*(Washtenaw Health Initiative, 2015)

Two of these goals are county-wide, with numbers attached to them; though they are not SMART measures because they are not timebound. The other three goals are more amorphous, and as such, make it difficult to know if the WHI is meeting its goals. The importance of shared measurement, according to the Collective Impact framework, is to ensure efforts remain aligned, hold each other accountable, to learn from mistakes and to course correct (Kania & Kramer, 2011). In this, it is not only important to have well-defined goals, but also to use them on a

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* SMART goals are Specific, Measurable, Achievable, Relevant, and Timebound

regular basis for the previously mentioned purposes. The WHI goals above were mentioned in the 2014 annual report. To date, there has been no 2015 or 2016 annual report. Moreover, not one person in my interviews, when asked about the purpose of the WHI or the data that WHI uses, mentioned these goals. They do not seem be used to drive WHI activities or to measure WHI's successes and failures.

Part of the reason that these goals may not be used to drive WHI's activities is the disconnect between the WHI's stated goals, its understood purposes, and its mechanisms for facilitating conversations and creating change. One WHI steering committee member describes the disconnect as follows: *"The WHI has big, bold ambitious goals, and the projects have been so small. Is the WHI's agenda too big?"* The implication of this quote is that the WHI operates using the Social Work/Policy and Planning coalition approach, but that to achieve some its goals, it may have to seek out projects that are more representative of a Community Development approach to coalitions.

One way to create this alignment could be to shrink the WHI's agenda to align with its activities and mechanism for change. Instead of attempting to improve healthcare access and coordination for the uninsured more broadly, it may attempt to serve as a forum for hospitals and social service organizations to network with one another. It could then focus on process goals of membership engagement and agency coordination. This would allow it to align one of its purpose with, with goals, and its current way of operating. Alternatively, it may sharpen its goals to a specific health issue and population (such as mental health services for low-income individuals in Washtenaw County). This would allow the WHI to build on existing activities, and drop some of its activities not aligned with this specific health issue and population without drastically reshaping the coalition's approach.

Another way the WHI could align its purposes, goals, and activities could be to explicitly focus its activities on health equity, expanding its goals to align with its purpose of improving healthcare access and coordination for low-income residents in Washtenaw county. By focusing on health equity, it would align its activities and measures to address the structural inequities that underlie many of the health issues faced by the low-income—racism and economic injustice. According to other collation models, a key omission in the Collective Impact model is its failure to focus on equity, a focus that the WHI currently does not have. A focus on health equity would require the WHI to actively use different data to measure its success as whole. In the Fall of 2017, PCMHs in Washtenaw and Livingston counties will begin screening their patients for social needs. This screening tool will include questions on housing stability, food insecurity, and financial resources strain. This tool is something that the WHI could use this data to create goals around the social determinants of health, not just traditional health measures. These data could be viewed in aggregate, as well as by race, ethnicity, gender, age, and by zip code. This would to understand not only is the whole population improving, but also if there are racial, gender, age, or geographic inequities which may or may not be improving (or worsening) at the same rate or direction of Washtenaw and Livingston counties as a whole. The WHI may then use these measure to influence the activities it undertakes, and how it engages those most affected by the issues (discussed below in Section E). Aligning goals and purpose around health equity and the social determinants would still require the WHI to change its culture. It would need to use these goals to hold itself accountable for achieving those goals, to allow for productive conflict, and to discuss failures.

Interviewees described several examples where the WHI projects used data to measure themselves and learn. It was noted that successful WHI projects had the following attributes: the projects measured their project processes; used the data from those processes to improve the project along the way; and learned things they previously did not expect when they undertook their process. The success of projects is not necessarily that they achieved a particular numeric goal they set out to do, but rather that they created community processes that led to better healthcare and social services. However, WHI projects do not generally have SMART goals. Like coalitions, without clear goals, projects can be hard to close. Clear goals may be necessary to determine if a project has concluded, but even if project did not meet a specific goal, it may have other process successes that live on after the project's conclusion.

E. Community Engagement is Slow, Challenging, and Necessary

Collective Impact has been criticized for failing to practice community engagement, a practice which many coalition models describe as essential to coalition success. After discussing the definition of WHI's community, I explore WHI's community engagement practices.

Another issue that the SIM brings to the WHI is the question of how the WHI should define its community. The SIM grant defines the CHIR as all residents in Washtenaw and Livingston counties. The WHI has before it the question whether Livingston county should be included for all of its projects, or just in the SIM. Defining community is also critical to the WHI's purpose. The question of whether it focuses on improving healthcare access and services for low-income residents or for all residents remains unanswered. Some interview participants worried that if the WHI doesn't explicitly remain focused on the low-income community, its

efforts and projects will drift towards the population as a whole, and the needs of low-income residents will be forgotten.

In some ways, this question of how to define the WHI's community mirrors the questions of how to define a hospital's community. The WHI may define its community by political or geographic boundaries, by those who receive services from its member organizations, or simply by the organizations that make up WHI membership. Using the broad definition of community as Washtenaw and Livingston counties, the WHI may be able to get more members at the table; however, it may have to operate in a way that conflicts with the goals of some of its members. For example, there has been discussion throughout the SIM about involving St. John Providence Health System, which currently does not have a major presence in Washtenaw or Livingston counties. However, St. John Providence is building an ambulatory care center in Livingston County, which will compete with SJMHS. To include them in the SIM is to give them greater standing within the community, which may be contrary to the goals of SJMHS, a WHI funder. Given the WHI's funding structure, it may be easiest to define their communities the same way that the health systems define their communities—either as the patients they serve, or as anyone that falls in their service region. The WHI might also define its community as the member organizations themselves rather than the population in the region, since that it is primary mechanism through which WHI works. The WHI needn't stick to one definition of community to move forward; however, when conflicts and tensions arise in the process of work, the conceptualization of the WHI's community may play a role in alleviating those tensions, or increasing them.

The Collective Impact framework lacks an explicit focus on community engagement (Kania & Kramer, 2016; Tom Wolff, 2016). The WHI also lacks a focus on community engagement—engaging those most affected by the healthcare access and coordination issues the WHI is seeking to address. One CHRT staff member describes a common theme amongst interviewees:

> *There really isn't a lot of community member involvement. One thing that's somewhat related to this is…it seems like the "community members" they pick are not actually "community members," they are just people who work in healthcare their whole lives.* - CHRT Staff

What is key in this instance is how a "community" is being defined. Observing the operations of the steering committee, the community is defined as members of the upper echelons of the healthcare community. The only qualification that makes them community members is that they are now retired and no longer working with a particular healthcare system. Other community members on the WHI steering committee are those in the business and social community that have a similar social and power status as the healthcare executives around the table. As one steering committee member noted, "*they represent a portion of the community that have relatively good health and good access to services.*" This relates to the purpose of the WHI and how it was formed: It was formed by health system executives to ensure the health systems were ready for the ACA. This purpose and way of operating is at odds with one of the WHI's goals to decrease the rate of uninsured in the county—a problem which primarily affects structurally disadvantaged populations (U. S. Census Bureau, 2015). The problems were defined by

professionals, and decisions were made by professionals with little input these populations, which is common practice in many agency-based coalitions (Tom Wolff, 2010).

There are many reasons why the WHI does not prioritize community engagement. First, and foremost is that community engagement is largely unfamiliar to those in the health system. To actively create a process with community engagement represents a loss in the familiarity of operations for these organizations. It requires a shift in mental models about how to appropriately tailor healthcare services. Second, there is a view that to do community engagement would get in the way of the WHI's effectiveness. One steering committee member describes this line of thinking: *"I totally value community-wide input. The threat that provide is it tends to grind organizations to a halt."* Those with experience in trying to bring hospitals and health systems together around the table are aware of how difficult it is to get hospitals and health systems moving in the same direction, and to engage community members represents a threat to this fragile process. I have observed concerns expressed by WHI steering committee members that a lot of time would be needed to get community members up to speed to be able to participate in technically complex conversations that occur at the WHI. This thinking is not without merit. Hackman (1976) states that group members must have the right level of heterogeneity to result in process gains. If communities most affected by the issues are participating in the WHI steering committees and work groups, there may not be enough common ground between members for the group to come together and work effectively. One CHRT staff member, however, observes that having community members slow down the conversations may be a good thing for the group overall:

> *I think [involving those most affected by the issues] would actually help, having that,*
>
> *because I think a lot of [WHI] members, anyone in healthcare, get so wrapped up in*

acronyms and phrases and terms that we assume each other know, that having a

community voice will bring that down to real life a bit more. -CHRT Staff

Facilitating meetings that avoid technical jargon is a practice that can increase community

engagement, and equalize power dynamics in meetings (Tom Wolff et al., 2017). This again,

requires a conscious effort on those in power to step outside of their comfort zone. Embedded in

the quote above also is the theme that having participation from those most affected by issues

can help all group members to elicit their mental models and assumptions as described by Senge

(2006), which is key to functional group work. There is a tendency to view this process as

something that slows down progress (a concept also discussed above around how the WHI sets

meeting agendas). However, one steering committee member notes that the work of engaging

community members is "*slow and messy",* which is a part of the work that you cannot avoid

without sidestepping key issues that may be integral to the work. If you don't practice

community engagement, a project member states that the projects "*will not have the impact you*

were hoping for." This aligns with what Senge (2006) describes as the fast shortcut is actually

slower in the long-run, because you don't account for necessary system dynamics.

Interviewees noted that to involve those most affected by the issues WHI seeks to

address, it is important to choose the right person, a person who takes the role of advisor to

present a perspective that is not in the room. The use of CHWs in the SIM presents an

opportunity to place individuals on the WHI steering committee or work groups, while providing

enough common ground so that the group can come together effectively. As they are involved in

the implementation of the SIM work, they will gain familiarity with healthcare and social service

issues to be able to be able to participate in WHI conversations. At the same time, with their

experience as members affected by the disconnect between healthcare and social services, these

CHWs can provide a hidden perspective that is currently missing from the WHI. I commonly heard throughout interviews that, as Wolff (2010) notes, community engagement can provide novel solutions as well as increased engagement from the community, making projects more likely to succeed.

In addition to being unfamiliar to many WHI members and slowing down meetings, another challenge to community engagement is that it requires significant time and effort outside of meetings. It requires continuous relationships with those who are marginalized, those who are difficult to engage, and those whom the health systems are not used to engaging. The WHI may not need to create its own community engagement strategies from scratch, but instead it may just use the existing consumer advisory groups of its member organizations. To do this would be consistent with its structure as an agency-based coalition (discussed more in Section F).

Lastly, true community engagement—involving members most affected by the issues when defining problems, agendas, and solutions for those problems—is most amenable to coalitions are based in the Community Development Approach/Community Capacity Development mechanisms. The WHI's implicit theory of change (discussed more below) is squarely in the Social Work/Policy Planning approach to coalitions—by pooling resources to conveying facts the WHI can change policy and delivery mechanisms. Participating in true community engagement would require the WHI to change its approach to coalition building. Furthermore, community engagement and community process is something that has to happen from the beginning a coalition. If not, community members and community-based organizations will disengage. Even if the WHI were to completely change at this point, bringing members who are low-income onto the steering committee, having open discussions about resource

distribution, the history of the WHI and its perception in the community would be a barrier to engagement at a community level from necessary stakeholders.

F. The WHI Is Viewed Differently by Those in the Healthcare Sector and Those Primarily in the Social Service Sector

In this last part of the results, I describe themes specifically related to the work of coalitions that seek to integrate healthcare and social services. I seek to enumerate the different roles of health systems, healthcare providers, social service organizations, and social service providers. Hospitals and health systems are powerful in comparison to many social service organizations. They are large institutions, and are not able to respond to all of their community partners, despite their best efforts. They may have a number of dedicated staff who want to engage with community members and social service organizations in a very authentic manner, but even so, they do not have enough capacity to respond to the needs and desires of community members and organizations. And so, anytime a health system describes its community work, however good or bad their work is, there are other community members and community organizations thinking about how the hospital is not working with their community in the way they would desire. In the interviews, participants from healthcare world saw the novelty in the WHI and complexity of organizing healthcare providers. Participants in the social services world viewed the WHI in the same way they view hospitals: as a large entity with power.

WHI helps health systems begin to navigate the social service sector, which is complex, opaque, and new

The following quote references the view that WHI is a unique. It is in healthcare coalition in a setting that is as complex—with multiple healthcare systems; it has broad geographic scope

(all of Washtenaw county); and has broad goals—not just focused on one disease, project, neighborhood, or population.

> *There are certainly are consortiums or collaboratives out there, but none that are an entire community as big as a county, and represent pretty much all the major public and private, although in this case non-for-profit, players*. -Steering Committee Member (from a health system)

The point of this quote is not whether there are other initiatives like the Washtenaw Health Initiative, but rather that these initiatives are perceived to be novel by those in the health system. Moreover, the notion of "major players" include health systems, but which social service providers are or are not at the table is largely outside of the minds of many in the health system. The hospitals recognize how hard it is to get all the hospitals and health systems in a community at the table on a consistent basis. Given the fact that the WHI has those hospitals and health systems at the table, and how much effort must go into keeping them at the table together, health systems are just proud of the fact that they are working together. Considerations of who is at the table in the social service sector is beyond the scope of what they are used to thinking of as who is a "player" in their field.

The quotes below are from two WHI members—one who works at one of the major health systems, and another from outside the major health systems.

> *In my mind, the WHI has the vast majority of social service providers at the table.* -Work Group Chair (from health system)

> *It doesn't feel like we're involving other players as much as we could. Again, at the table, there are so many people not at the table, that don't understand or know what WHI is*. -Work Group Member (from outside a major health system)

These juxtaposed quotes illustrate challenge as health systems move into the social service realm—this is new for them, and just having any social service providers at the table is a big step. This does not speak to the complexities and politics in the social service sector, which WHI members from outside the health systems are aware of, but are not addressed within the WHI. Figure 4 on the next page is a member map of the WHI overall in 2016.
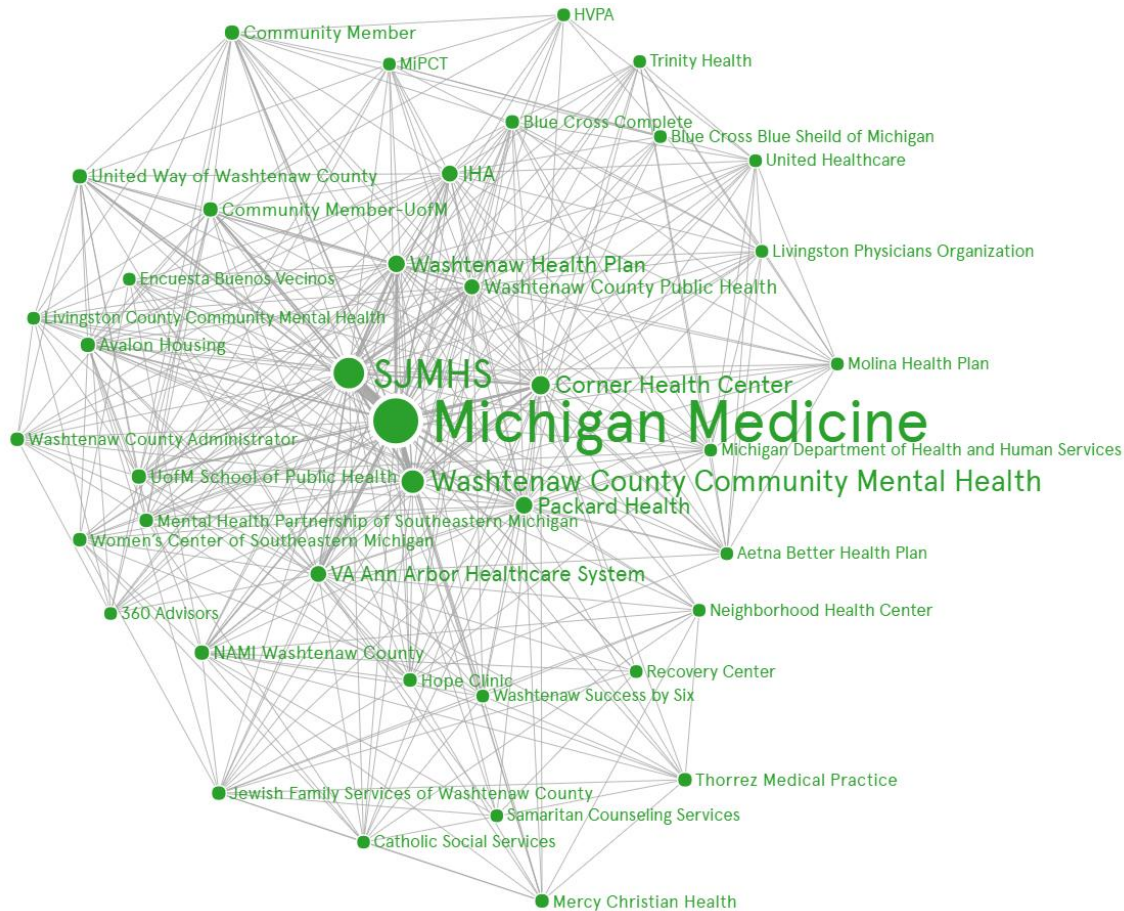
Figure 4. WHI 2016 Member Map

Much like the steering committee and the SIM maps, this map shows MM at the center of the WHI, with SJMHS also playing a large and central role. The Washtenaw County Community Mental Health and select healthcare clinics are also central to the effort, but nowhere near as big as the health systems. In all the member maps, social service organizations are on the

outside looking in, and many connections flow throw the health systems. This may be one reason that members of the health system feel as if more people are involved than the social service providers. While the WHI facilitates connections between the two health systems, and between the health systems and social service providers, it does not necessarily facilitate strong connections between different social service organizations.

I observed this in my work on the SIM with the WHI. There have been several occasions where it has been brought to the attention of CHRT staff and WHI members which social service providers are not at the table—particularly those in Livingston County, where the WHI has not traditionally worked. If those organizations mentioned were easy to engage, and motivated to come to SIM meetings on their own, they were invited to do so. However, active outreach to social service organizations has been a relative afterthought to many involved in the SIM. This is likely for the same reason more are not involved in the WHI: there is already a significant amount of work needed to simply get the hospitals, health systems, and clinics at the table, and getting them their takes up nearly all of CHRT's energy, whose focus is not naturally inclined to the social service world.

This view of the social service world may have to change with the SIM project. The WHI is no longer just a coalition whose efforts are mostly driven by in-kind donations, but rather a coalition with soft funding from the state government and from local hospitals, funding which the WHI is charged with distributing to the community with the goal of linking healthcare and social services providers. There are calls for the WHI to engage in a fair and transparent process for distributing the money. These represent a call for them to be open to all social service providers, not just those currently at the table. The combination of desiring a successful improvement in coordination between healthcare and social services, and the need to give money

to social service agencies requires the WHI SIM leadership to repeatedly ask itself: do I have the right social service providers at the table? As represented in the potential losses of the faction map for WHI steering committee members, this iterative question may lead many in the WHI outside of their comfort zone—away from the familiar world of healthcare services and towards the unfamiliar world of social services. It remains to be seen how far out of their comfort zone the WHI is will to extend itself. As hospitals and health systems are being asked to step outside of their traditional line of services, they are entering an unfamiliar setting, a setting in which much of their experiences in treating patients* does not apply. The WHI helps health systems navigate the social determinants of health—which is distinct from, yet related to navigating the social service sector.

There are Differences in Healthcare and Social Service Delivery Models and Culture

In the healthcare sector, the responsibility of providers traditionally ends when a patient leaves the providers office. Anything that happens outside the office is generally the patient's responsibility—including scheduling appointments, fulfilling prescriptions, obtaining and managing health insurance, and following medical advice. The techniques and procedures available to providers are learned through a combination of didactic and apprenticeship training programs (such as medical, nursing, and physician assistant rotations, residency, and fellowships). Moreover, the problems of patients are defined by the healthcare provider, though the patient may have input in this definition.

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* In the healthcare system, people who receive services are generally referred to as "patients." In the social service sector, people who receive services are generally referred to as "clients." Though there is much debate around the implications of such terms (Gotz, 2001; Simmons, Hawley, Gale, & Sivakumaran, 2010; Wing, 1997), for this dissertation, I use both terms interchangeably, referring to "patients" when describing the views and practices of those in the healthcare system, and using "clients" when describing the views and practices of social service providers.

The problems that the social service sector seeks to address, for the most part, do not allow themselves to be neatly packaged. There is a lack of clarity in what is the responsibility of the client, what is the responsibility of the social service provider, and what is the responsibility of government and other organizations. Although there are bachelor's and master's social work program's that do offer training parallel to that of the healthcare providers, many who work in the social service sector do not have formal training—that is not say they are not skilled, but rather the skills are not easily adapted to the medical model of care. Finally, in many cases with social service providers, the client works alongside the provider to define the problem.

The WHI is an agency-based coalition, driven by the hospitals

> *In the community, [WHI] is perceived as a provider-based, hospital-oriented organization…that is explainable from the inside by its genesis, and where it's life-blood is going to continue. It has nonetheless billed itself, and to some degree, has believed in itself, as a community-based organization. Disconnect has arisen…What you've got is small number of safety-net health centers, not social service agencies and not the whole realm of health-related entities.* –Steering Committee Member

When the WHI began in 2011, it was formed by hospital executives to prepare the county for the implementation of the ACA. They wanted to make sure that the hospitals and health systems were ready for those who would gain insurance. The primary mode of action was to work health systems, providers, and other health-related organizations existing in the country. The WHI did not form from the desire of individuals that would soon be eligible for insurance through the ACA, and the primary mode of action has been through agencies, not those individuals. The WHI is what Wolff (2010) describes as an agency-based coalition, rather than a community based coalition. Communities are viewed as the site of problems, problems which

professionals can solve through technical expertise (Tom Wolff, 2010). The WHI should not bill itself as a community-based initiative. Acknowledging its role as an agency-based coalition may help to clarify WHI's role in the community as well as to alleviate the concerns raised in the member survey and the interviews—that WHI takes credit for other agency's work.

The WHI is viewed as competition to social service providers, for funding and as a source of expertise

One WHI steering committee member from a health system noted: *"We don't compete over care for the poor. There is plenty of need."* Hospitals don't see themselves as competitors or even in the same field as social service organizations. In many senses, that is true. They are so much larger than many social service organizations, and serve different functions, that they are largely not direct competitors to social service organizations. However, as they enter the social service field with efforts in population health, the relationships they make and programs they fund do influence social service organizations. Even if they don't compete directly with social service organizations, by choosing to learn from the WHI—and by association, from CHRT—they are choosing not to learn from the social service providers themselves, something social services providers are keenly aware of as exemplified by this quote from a member of social service organization:

> *For community organizations, it's not so much being celebrated, but being recognized for their expertise. Physicians and hospitals do not have all the knowledge when it comes to impacting public health. And if anything, I would argue communities [and] organizations have far more experience and expertise at the grassroots level in understanding what it takes to really create behavior change and impact public health. –*
> WHI Project Member

Though this quotation explicitly critiques hospitals and physicians, it implicitly critiques the hospitals' use of the WHI as their guide into the social determinants of health world. Numerous interviewees commented on the fact that the CHRT does not have experience providing direct services to the low-income community, and thus does not have the expertise to guide a coalition in improving health and social services to the low-income community. The WHI and CHRT may have stayed away from the world of direct service provision to avoid the appearance of competition with other non-profit organizations. Nevertheless, on survey comment notes that some do view it as a competitor for funding: "*It promised it wouldn't compete for funding with direct service agencies, now it is doing that.*" It was the sense by several interviewees that the WHI was taking resources that would otherwise be given to nonprofits. These concerns may just be the natural response of organizations whose territory is now being encroached upon by the hospitals. However, the fact that many social services organizations are on the outside of the WHI looking in, breads a sense of competition.

IV.   Conclusions

A.   What are the implications of the WHI's alignment with and departures from Collective Impact and other coalition models?

In many ways, the WHI is similar to other coalitions. It formed in 2011 in response to an external stimulus the, the ACA. When it began, it did not adhere to an explicit coalition theory. Rather, based upon the knowledge of those involved, it developed implicit norms for operating. Only after it had been established as a coalition did it adopt the Collective Impact model. The WHI's adoption of Collective Impact was a retrospective examination of the WHI's operating processes, and agreement that they seemed similar to those that were described by Collective Impact. This adoption was never intended to be used as framework by which the WHI might measure its current activities, and change them in order to align more with the framework. I will attempt to do that here.

The Collective Impact model has five key attributes: 1) a common agenda; 2) shared measurement systems, 3) mutually reinforcing activities, 4) continuous communication, and 5) backbone support organizations. The WHI does not have a single common agenda, but it does have one more salient agenda and general consensus around two other agendas described above. Given the fluidity of the coalitions and the diversity of stakeholders, a common agenda may not be necessary in the WHI—something that is acknowledged in the evolving Collective Impact model as *common agenda* shifts to *community aspiration* (Cabaj & Weaver, 2016). The WHI uses shared measurement at its work groups and projects, but it does not appear to measure itself at a coalition level. It has many stakeholders together at the table, creating the possibility to develop mutually reinforcing activities, but it does not yet fulfill this attribute. This is perhaps due to a lack of focus on changing the internal workings of its coalition members, and lack of a

holding environment to manage conflict constructively, which are part of Wolff's Nine

Dimensions of Successful Coalitions (Thomas Wolff, 2001).

The continuous communication attribute requires that communication occur both inside

of and outside of meetings, and that the commitment of CEOs will trickle down their

organizations to create an atmosphere of communication across organizations. This

communication does happen selectively in the WHI, especially amongst healthcare

organizations. However, given the feedback from the member survey and the interviews, it is

clear that not all organizations feel the same, especially those organizations whose CEOs are not

around the steering committee table. With only one member from a social service organization

on the steering committee, the WHI may need to expand its steering committee membership or

find better ways to facilitate connections that don't flow through the health systems, if it is to

engage social service organizations through the Collective Impact model.

The WHI's backbone organization, CHRT, is the attribute with which the WHI most

aligns with Collective Impact model. CHRT has significant resources, can convene stakeholders

and move tasks forward. CHRT creates a place where information can be shared and technical

assistance can be provided, a key dimension in coalition success (Thomas Wolff, 2001). At the

same time, the backbone organization is a source of departure from other coalition theories. The

roles of individuals and organizations in the WHI are not clear to those involved. This is a key

component of Wolff's Nine Dimensions of Successful Coalitions and Collaborating for Equity

and Justice (Thomas Wolff, 2001; Tom Wolff et al., 2017).

Collective Impact is appealing as a model because it is simplified. Many coalition

members, especially those that have are high-level or have significant work experience, do not

have the time or interest to devote to understanding other coalition theories. The WHI does not

actively use the Collective Impact model, which some of its members are familiar with. Accordingly, it pays no attention to the evolution of Collective Impact, or to the other coalition theories described here. The WHI does not engage in strategic learning at coalition level or focus on community engagement, both attributes included in the evolved Collective Impact framework as well as other coalitions theories. This lack of interest in evolving the coalition may be a source that recreates the problems that coalitions are hoping to solve, what Heifetz calls mirroring. In this particular coalition, it is likely the backbone staff, who must step beyond the scope of their formal authority to provide an impetus for coalition members to question their processes, to look more in depth about how coalitions are similar to and distinct from their previous experiences. Doing this is not simple, as many times, backbone staff are less experienced and younger than coalition members, especially in the Collective Impact model which calls for CEOs to be at the table. Yet, coalition staff may be the only ones with the perspective to understand the internal dynamics and processes of the coalition. If change is to occur in the Collective Impact model, backbone staff must take a risk, they must exercise leadership to raise the level of discomfort into the zone of productive disequilibrium, so that coalition members are forced to change their behaviors, forced to create process gains rather than suffer through process losses, forced to create new ways to solve problems.

Recommendations for the WHI: as coalitions mature, more structure is needed

From 2011 to 2014, the WHI had a relatively small group of organizations, and a relatively clear purpose. Having clear goals and few members, little structure was required to keep the WHI working towards its purpose. In 2014, it engaged in a strategic planning process to decide whether or not it should continue after the ACA was implemented. Resulting from this process was an expanded list of goals, as well as a goal to expand its membership. The WHI

grew, but the processes which had previously served the WHI when it was smaller and more focused no longer were sufficient for it to achieve its goals. Senge notes that this is common with organizations. As they grow, because of previous successes, there is a tendency to simply repeat the same patterns of behavior that lead to this earlier success (Senge, 2006). The WHI, in part because of its previous success, and in part because of it lacks an internal drive to become a learning coalition, has yet to develop process which support its expanded membership and goals.

From the interview results, member survey data, and my own observations, the following changes to WHI structure may be helpful in achieving its expanded goals as a maturing coalition:

- *More clearly define roles of steering committee members, chairs, work group and project members, as well as CHRT staff.* All members should be expected to come prepared to meetings, having read meeting materials. The WHI Steering Committee should revisit its decision-making process, with the help of an outside facilitator so that the same power dynamics inherent to the consensus process are not recreated. An explicit executive committee should be recognized for the creation of agendas and materials to bring to the steering committee. Steering committee members should be assigned to work with work group and project chairs to ensure that the groups activities are aligning with the WHI's goals and that the chairs have the support and skills they need to facilitate a functional work group or project. Chairs should be responsible for assessing member engagement of their group, expected to assign action steps to members, and to take responsibility for ensuring action steps are carried out. Work group and project members should expect to leave meetings with action steps to complete in between meetings. CHRT staff should be have the responsibility of setting meetings dates, working with chairs and executive team

members to send out agendas, taking meeting notes, creating meeting summaries, and posting these summaries to the WHI website. CHRT staff members should not be expected to carryout action steps from meetings on their own, as is the current norm.

- *Define norms for meetings and facilitation techniques.* The steering committee, work group, and project chairs should be responsible for ensuring the following meeting norms and facilitation practices are present in every WHI meeting:
    - Meeting materials and agendas are sent in advance
    - Introductions are made at every meeting.
    - Meetings end on time.
    - WHI members, not CHRT staff, are responsible for follow-up steps
    - Meetings have meeting summaries, documenting follow-up steps and unfinished conversations
    - Follow-up steps and unfinished conversations are reviewed at the current meeting, and carried forward if not complete
    - Meeting facilitators summarize conversations on one topic before moving onto the next topic
    - Meeting facilitators actively seek to engage as many people as possible at the meeting.
    - Meeting facilitators ask members to raise concerns to uncover hidden perspectives and make projects more likely to succeed as these perspectives are addressed.
- *Define a process for taking on new projects, which include reviewing data to define a need and active community engagement.* With any new project, data should be used

to define the problem that the project is seeking to address, as well as the proposed

solution. Data may include numbers that represent a need, but it may also consist of

qualitative reports from those actively working with members of the target population

of the proposed project. Before undertaking a project, WHI should ask itself, 'How

have members of those most affected by the issues been involved with the definition

of the problem and solution proposed in this project?' They may be a part of the

project working to solve the issue at hand, or they may be engaged through the

consumer advisory boards of the WHI's member organizations.

More structure does not equal more central control; conversely, it means creating a

structure that distributes responsibility more amongst coalition members. Through this work, the

WHI may become a learning organization, which "extend[s] the maximum degree of authority as

far from the top as possible" (Senge, 2006, p. 287). In a structure that distributes responsibility

more widely, power dynamics across individuals and organizations are equalized, allowing for

greater member engagement and learning. Moreover, as responsibilities are more distributed and

clarified, if tasks get dropped, it may provide an opportunity to examine why that task was

dropped—a process which can lead insight into the challenges faced by the coalition in its

operations, as well as insight into some of the hidden challenges which may be at the root of

problems which the coalition is working to solve.

Simply attempting to implement the recommendations above will not lead to the success

of the WHI. CHRT cannot, on its own, codify these recommendations and will them into reality

without proper engagement from members of the WHI. WHI members must individually and

collectively grapple with whether they believe these recommendations will help improve the

WHI, adapt the recommendations to align with what they think will help and what is possible,

and take ownership over implementing them. This is a lot to ask, given the volunteer nature of the WHI; however, a coalition's strength, comes from the its members' engagement and learning.

B. What are the specific opportunities and challenges that coalitions seeking to integrate healthcare and social services face that individual organizations do not?

Coalitions can provide a service to hospitals as they foray into population health, but should recognize the expertise of those already working in those spaces

The type and formation of a coalition influences the type of work that can be done. A coalition that is formed by and driven by the hospitals, is likely to remain within in the realm of services that hospitals are used to providing. As it is currently structured, the WHI provides a semi-consulting service for the hospitals. It helps the hospitals understand their new programs in population health, the social service space, and the social determinants of health, but it is not community-driven (either by more grass-roots social service organizations or by members of the low-income). It falls squarely in the category of an agency-based, betterment coalition, a coalition which does not threaten existing power relations. However, it is a lot to ask of hospitals and health systems to provide funding for coalitions, but to take a step back and let social service organizations or individuals from their communities partner in setting the agenda of these coalitions. Not only does this represent a loss in control of how the money is spent and a threat to existing power structures, it also represents a change in culture in the way the hospitals (and most organizations) operate. Moreover, the integration of healthcare and social services represents a shift in culture in the way health systems traditionally view people. As described by Bradley and Taylor (2013), social services view the whole person, as opposed to the specific

need. A coalition designed to integrate the two requires the space for hospitals and health systems to adjust their culture to view the whole person. Social service organizations participating in coalitions may be impatient with the slow pace at which health systems change their cultures and rediscover some of the same lessons that social service organizations have known for years. A coalition needs to be able to hold these tensions, and steer them to productive collaboration and shared learning between members.

To build a successful coalition that integrates healthcare and social services, adjustments are needed from health systems, social service organizations, and community members. Hospitals need to give up some of their power in a coalition's structure and agenda, and acknowledge the expertise of social service providers and community members. They must engage community members beyond an advisory capacity, but work alongside them as decision-makers, have patience to understand the slow progress that interventions take when meaningful engaging with community members. Much of the knowledge of coalitions is not documented in peer-reviewed journals, but rather passed down orally within communities (Thomas Wolff, 2001). This strikes me as very similar to the knowledge that exists in the social service sector as compared to the medical sector. Social service providers must be willing to the play the role of guiding the hospitals through the resources, challenges, and politics of providing social services. They must be patient with hospitals and health systems as they learn the intricacies of the perpetually underfunded social service world. At the same time, social service providers must also recognize that they too are navigating new terrain in a complex, healthcare system, one which they cannot expect to function seamlessly just because it is better financed than social services. Community members must be active in their community, engaging with both health

systems and social service organizations to provide their expertise, as well as to learn about the complexities involved in health and social service provision.

The burden and expectation of making these adjustments, because of their power and the resources available to them, falls primarily on health systems. Social service providers and community members have roles to play in changing themselves, and helping hospitals be responsive to their needs, including putting pressure on them when they move too slowly. Coalitions can serve the role of bringing these different stakeholders together to help them change, but, as one WHI work group member noted, just bringing them to the table doesn't assure success: *"I don't know in terms of outcomes what they've achieved, but at least it's gotten a lot of people at the table. So it's a start."* To be successful in integrating healthcare and social services, coalition's mission, approach and activities must be in alignment.

Coalitions must align the mission, approach and activities to appropriately engage members and achieve their goals

If a coalition's mission, approach, and activities do not align, then it is unlikely to achieve its goals. Most of the concerns about the WHI raised in the interviews and members survey were a result of this disconnect. As a result of this disconnect, and a perceived in ability to change this, some WHI members have begun to disengage. Acknowledging what the WHI is, and is not, may go a long way to ensuring that they get the right member engagement to achieve appropriate goals.

The WHI's mission is to improve health and healthcare in Washtenaw County with an emphasis on the low income, uninsured and underinsured populations. It uses a Social Work / Planning and Policy approach to do this. Coalition members are expected to coordinate and delivery services, while lobbying for more resources to provide those services. The WHI's

activities create the space for its members to coordinate and deliver services; however, they do not create an environment that pushes members focus on the work they themselves must do in order to improve service coordination and delivery. Creating that environment is extremely difficult, and requires skills and resources which may not be present at the WHI. Similarly, the WHI is an agency-based coalition, rather than a community-based coalition. If the WHI decides that creating that environment is beyond what it is capable of, or what it desires to do, and that it doesn't wish to become a community-based coalition, then it should explicitly acknowledge that. Its mission may be scaled back to simply providing a space for organizations to come together and work on shared problems—rather than the improvement of healthcare services as a whole.

The WHI does have efforts to lobby for more resources for healthcare and social services. The sources of funding they lobby for are largely those from payers, as well as from some of their hospital members. They work under the premise that facts will change the mind of payers—particularly arguments about ROI. This is the approach the WHI is taking with the SIM plans for sustainability. However, there are many activities undertaken by the WHI's member organizations that do not have a positive ROI, but still need more resources in order to provide better services for the low-income, uninsured, and underinsured. In this case, simply presenting facts to payers will not suffice. Moreover, the payers, are largely absent from the core work that the WHI does—though they do monitor what is happening at the WHI, they are not active participants. Coalition efforts can be successful without data supporting their positions (as is the case with activities that are worthwhile that do not show an ROI) and without having the people at the table who they hoping to change. However, these coalition efforts usually take an Activist/Social Advocacy approach to coalitions. The Social Work/ Planning and Policy approach does not explicitly seek to upset existing power relationships, and despite the best

intentions, in an effort to not disrupt the equilibrium too much, the solutions proposed may end up reinforcing existing power structures which lead to health and social inequities. Even if the WHI desired to take another approach to coalition work, because of its current member engagement, community engagement, mode of using CHRT to carry out most of its work, the WHI is not structured to have an Activist/Social Advocacy Approach.

All coalitions aspirations are beyond their reach, at least initially. The problem is not that the WHI's aspirations are too high, but rather that the aspirations do not represent the current approach that the WHI takes. The way the WHI is structured and the problems the WHI attempts to address or does not attempt address are no different than most organizations. What makes it problematic for the WHI, is how it talks about itself—or at least how its members who participated in the interviews and the survey perceive it to talk about itself. In the interviews and in member surveys it was often described that the WHI purports to be community-based a coalition focusing on the needs of the low-income population in Washtenaw County. It is, however, more of an agency-based coalition focusing on the needs of hospitals and health systems as they navigate the new healthcare environment. If the WHI were to be explicit about its theory of change and its goals, and hold itself responsible for meeting those goals, it may be able to resolve the dissonance between what the WHI purports to be, what the WHI is, and what WHI members want it to be.

At the same time, it may be the unfair of some of the social service members to expect the WHI to be something it is not. They see the challenges they face as social service organizations, and expect WHI to be a venue through which they can address the problems they have—much of which originate at funding level. They simply do not have enough resources to provide the services their clients need. The WHI is not built to change the funding structure in

society. Furthermore, many social service organizations have a community development and social justice approach to their services, and they expect the WHI to have a similar approach. Given that the WHI's funding is primarily through the hospitals, this expectation may also be unrealistic. It may be better for social service organizations to work in a different effort, one that aligns with the social justice framework, that takes either community development approach, or even an activist approach. When hospitals, social service providers, and community members work in coalitions to integrate healthcare and social services, it may be helpful to explicitly name the coalition approach. It is not necessary to have one common agenda between multiple organizations, but it is important to have an explicit purpose, theory of change, structure for achieving that change, goals, and to be responsible for achieving those goals. This can help member organizations assess how much the coalition's work aligns with their organizational mission and theory of change, as well as set expectations appropriately of the discussions and actions that will occur in the course of coalition activities.

Limiting the issues surfaced by coalitions limit its solutions, which in turn limit a coalition's ability to address the root causes of health inequity

The goal of the SIM is to improve coordination across health and social service agencies. Implicit in this goal of improving coordination with both the WHI and the SIM is that the root of many problems are in health and social services is a lack of coordination. However, addressing a lack of coordination may just be a form of what Heifetz calls *work avoidance* and the tendency that Senge (2006, p. 104) notes of people to "shift the burden" of the problems to other, easier solutions—often leaving the underlying problem unchanged. The real work of the community may not be that services are poorly coordinated. Rather, the real work may be recognizing that in a region that is liberal and highly educated, there can still be health, social, and economic

inequities, and that the problems facing our region are the same as those across the nation: that

we don't invest enough money in social services. As a result of underfunding of social services

at every level of government, these services are stretched thin, having many gaps within the

direct services provided as well as in coordinating between different organizations. The WHI

members may say that a lack of coordination of services is a problem, because that avoids

placing blame on anyone in particular, and avoids conversations about resource redistribution.

> *You have a highly-educated community, and it's very segregated by SES [socioeconomic*
>
> *status]…that's how the dental practices are. There's the Medicaid practices, and there's*
>
> *everyone else. So there are concerns about having those people in the waiting room,*
>
> *with regular patients. I think a lot of this is classism, racism comes into play, that people*
>
> *swear they don't have, but they do. They just say it nicer in Ann Arbor*. -Project Member

Although the previous quote was about dental practices in Washtenaw County, specifically Ann

Arbor, it might be applied to way in which healthcare and social services are currently separated

across the nation. We have a system of healthcare that works for those in society who are part of

the white upper or middle class. If the coalitions are to be used to improve healthcare for the

low-income, and to integrate healthcare and social services, they must follow the first principle

in Collaborating for Equity and Justice: Explicitly address issues of social and economic

injustice and structural racism (Tom Wolff et al., 2017). The lack of conflict in the current WHI

indicates either that 1) those who control the WHI's agenda don't wish to address racism,

classism, justice, and resource distribution or 2) that the holding environment created by the

WHI and similar coalitions is not strong enough to endure such a conversation, and thus, those

setting the agenda avoid these topics for the stability of the coalition. By avoiding these

challenging topics, the participant's mental models and the solutions explored by the WHI are only those that reinforce the current distribution of power and resources.

Given the focus on the social determinants of health framework in the WHI (and in other efforts to integrate healthcare and social services), the limited discussions and solution space are somewhat expected. Krieger notes in her book *Epidemiology and the People's Health* that in this framework "relatively little attention [is given] to the underlying political-economic systems and their varied structures, priorities, and conflicts that give rise to the material and social circumstances relabeled as 'social determinants of health'" (Krieger, 2014, p. 184). As a result of this inattention to political-economic systems, the solutions offered by this framework "typically do not embrace explicit political or economic analysis of whose interests are serve by extant inequities. Nor do they call attention to the considerable effort those benefiting from the status quo exert to ensure they continue to accrue their benefits and hold onto their wealth and privilege" (Krieger, 2014, p. 184).

I observed this firsthand in Michigan with the current state and the solutions offered to address the social determinants of health. Although there has been a lot of public rhetoric pushing risk-based contracts in ACOs, in Michigan, there are very few risk-based contracts, and those that do exist are mostly up-side risk only. In theory, risk-based contracts might allow for the shifting of resources from individual, facility-based services to population-targeted services that could change socioeconomic environmental factors at a community or neighborhood level. In practice, there has been little meaningful change in provider practices to address social determinants of health as a result of these risk-based contracts. This is not all-together surprising. The move to risk-based contracts is slow in part because those who benefit from the status quo, payers and providers, and the same as those in charge of changing the status quo. In Heifetz'

framework, the level of disequilibrium is not quite high enough to push them to change. Gotliebb et al. (2016) describe the administrative cost and the delay of reaping the benefits for payers investing in addressing the social determinants of health. In addition to financial risk and the costs associated with changing payment models and provider models, costs which are certainly not small, providers and payers face non-financial "losses": loss of familiarity in the current operating environment, a loss of the view that improvements in population health can be achieved through services that address individual-level factors, and the loss of control over services which would be subject to more outside forces in the socioeconomic world.

Moreover, the solutions offered in the SIM project have mostly been to "turn on" insurance codes that would allow for social service providers to bill from some of their services. The codes discussed are for services to connect and navigate individuals within the system (e.g. case management), but for services that would actually change the social environment (e.g. payments for affordable housing for the homeless, payment for air conditioners for asthmatics, or payment for transportation to purchase healthy food). These solutions, by and large, maintain the status quo, maintain the current operating environment, maintain the current distribution of resources.

There are, however, examples in Michigan of health systems working to address the social determinants of health. Trinity Health announced a $80 million project over five years in six communities to invest in the actively building healthy communities, which they hope will reduce the cost of healthcare (Taylor, 2016). This type of investment is likely a result of a mission driven organization's commitment to its communities and the fact that margins for hospitals at this time are as high as they have been since the 1970s, when Medicare and other payers began their efforts to address the cost of healthcare. It is important to note, that although

changing payment models may be influencing this type of investment, that the actual mechanism

for this investment is through the health system's community benefit department, not as a part of

the normal mode of service delivery through contracts with payers. Payers are not involved in

this (though they are certainly aware of it). Without the connection to contracts and payers, it is

easy to see where community benefit investments, which are not required by law to be at any

particular spending level, may simply go away when individuals championing the issue leave or

when the healthcare financial environment shifts. Changes to address social needs which are not

entrenched in the systems of healthcare delivery are not enduring solutions.

On the one hand, the approach of working outside the system of payment models may be

the way to get a foot in the door, a starting point to eventually embed social services into

healthcare delivery. On the other hand, it could simply be a way to avoid truly doing the hard

work: working with physicians to acknowledge and address their losses in the changing model of

care; working with payers to address their financial losses as well as their views on payment

mechanisms and healthcare delivery; working with social services providers to understand that

change in the medical system may be slow and needs to happen at system and institutional level

as well as at an individual level; engaging with disenfranchised communities in a slow process, a

process that acknowledges everyone as people, rather than viewing them as a conglomeration of

diseases, conditions, and needs; recognizing that economic and social inequities, as well as

structural racism are at the root of many health and social issues, and that any effort to address

these health issues without acknowledging and addressing their root causes may be ineffective.

C.   Areas for future work

There are many topics that remained to be explored in the use of coalitions to integrate

healthcare and social services. One is to understand better how the boundaries of healthcare

services and social services affect the efforts to integrate these two fields. For example, it may be worth exploring the concept of patient-centeredness. It may be worthwhile to explore the mental models of providers in PCMH, to understand where the boundary is for their patient-centered services. Is the boundary one that is defined by services healthcare providers offer, or is it defined by the services that a patient needs? Furthermore, it may be worth exploring the cultural differences in healthcare and social service providers, and how this affects their experiences working together—both in coalitions for planning and organizing purposes as well as with specific patients and clients. Related to this, it may be important to understand the role that internal dynamics within the healthcare and social service system between different provider types (e.g. physicians vs. nurses, harm reduction substance use providers vs. abstinence-focused substance use providers) play in the integration of healthcare and social services.

Another area of study that is pertinent to the use of coalitions in integrating healthcare and social services is how to appropriately address the challenges of time horizon and ROI. Many social service programs will not show a positive ROI, and certainly do not show a positive ROI in a short time horizon. That doesn't mean that they are not cost-effective, or not worth doing. It is worth exploring how programs that integrate health and social services may use SROI, or alternative methods to look beyond ROI, and expand the time horizon of these programs. A correlated issue to explore further is how to engage commercial payers in the integration of healthcare and social services, especially when there is no apparent positive ROI.

Finally, it is necessary to explore how the concept of equity is incorporated into coalitions that integrate healthcare and social services. Without the explicit goal of improving health equity, many coalitions may simply reinforce existing structural inequities which are the root of many health and social issues. However, there are few examples where hospitals, health

systems, and payers engage in these efforts. Part of this work may be working towards a common definition of population health, that recognizes a population defined as broader than an organization's members or patients. City, county and state public health agencies may be able to play a role shepherding a common definition of public health. Additionally, it may be worthwhile to explore the boundaries in responsibility between coalitions and government. Perhaps the need for coalitions to come together to address health equity through the integration of healthcare and social services is representative of our society's unwillingness to address health equity. The goals (and outcomes) of healthcare and social services really do "derive from the goals of the larger society for itself and from the view that society holds of itself and of its various members," (Stern & Axinn, 2012). Coalitions have the potential to help shape societal goals, but it is a potential that must be cultivated.

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VI. Appendices

Appendix I: SIM Governance Model

WASHTENAW HEALTH INITIATIVE

Washtenaw / Livingston Community Health Innovation Region (CHIR)

SIM MDHHS State Innovation Model

WHI Co-Chairs
- Norman Herbert, Retired, University of Michigan
- Doug Strong, Retired, University of Michigan Health System

SIM Work Group Co-Chairs
- Doug Strong, Retired, University of Michigan Health System
- Paul Valenstein, St. Joseph Mercy Health Partners Clinically Integrated Network

CHRT BBO Support
- Nancy Baum, Health Policy Team Manager
- Leah Corneail, Policy Fellowship Program Manager
- Megan Foster Friedman, Healthcare Analyst
- Jeremy Lapedis, Healthcare Analyst
- Carrie Rheingans, Washtenaw Health Initiative Senior Program Manager
- Marianne Udow-Phillips, Director

Chart boxes: MDHHS → WHI Steering Committee → SIM Work Group; CHRT BBO support; Intervention, Data/IT, Clinical (PCMH/ASC), Community Health Improvement

Intervention	Data/IT	Clinical (PCMH/ASC)	Community Health Improvement
Co-Chairs: Ray Rion, Pam Smith • Avalon Housing • Blue Cross Blue Shield of Michigan • Blue Cross Complete • Community Mental Health Partnership of Southeast Michigan • Community Mental Health Services of Livingston County • Gerald R. Ford School of Public Policy • Institute of Health Policy and Innovation • Integrated Health Associates • Livingston County Public Health • Livingston Physician Organization • Packard Health • Michigan Primary Care Transformation Project • St. Joseph Mercy Health Partners Clinically Integrated Network • Saint Joseph Mercy Health System • University of Michigan Health System • United Way of Washtenaw County • Washtenaw County Community Mental Health • Washtenaw County Public Health	**Chair: Mike Klinkman** • Corner Health Center • Michigan Health Information Network • St. Joseph Mercy Ann Arbor and Livingston • Trinity Health • University of Michigan Health System • University of Michigan Medical School Department of Learning Health Sciences • Washtenaw County Community Mental Health	**Co-Chairs: Maria Han, Marti Walsh** • Blue Cross Blue Shield of Michigan • Blue Cross Complete • Corner Health Center • Huron Valley Physicians Association • Integrated Health Associates • Livingston Physician Organization • Michigan Primary Care Transformation Project • Saint Joseph Mercy Health System • St. Joseph Mercy Health Partners Clinically Integrated Network • UnitedHealthCare Plan • University of Michigan Health System	**Co-Chairs: *(tentative)* Michael Miller, Maria Thomas** • Community Mental Health Services of Livingston County • Livingston County Public Health • Packard Health (FQHC) • Saint Joseph Mercy Ann Arbor • Saint Joseph Mercy Chelsea • Saint Joseph Mercy Livingston • University of Michigan Health System • Washtenaw County Community Mental Health • Washtenaw County Public Health ***This committee will form late 2016*

The Washtenaw Health Initiative is a multi-stakeholder collaborative which includes Washtenaw County Public Health, Livingston Department of Public Health, Washtenaw and Livingston Community Mental Health and many other organizations in both Washtenaw and Livingston counties. The Washtenaw Health Imitative is hoping to understand care and case management services in Washtenaw and Livingston Counties as we prepare to implement the State Innovation Model (SIM) project in our region. The project's goals will be to link clinical and community services in order to reduce emergency department utilization in our region. The survey will help us create an intervention that builds upon current case management efforts and fills the gaps in existing services. If you are a care or case manager, or you are responsible for a program that provides care/case management services, please take about 10 minutes to fill out this brief survey by November 11th. If you have any questions about the SIM project or additional questions about this survey, please contact Jeremy Lapedis (jlapedis@med.umich.edu).

Q1 What is the name of your organization?

Q2 If you work for a large organization, please answer the remaining questions for your department and put the name of your department below. If you don't have a department, please leave the following answer blank.

Q3 What is your role at the organization?

○ Frontline Staff

○ Manager of Frontline Staff

○ Program Director

○ Other (Please Specify) _____

Q4 For your case/care management services, who refers patients/clients to you? (Select all that

apply)

❑ Primary Care Providers

❑ Emergency Department

❑ Discharge Planners

❑ Hospitals (other than emergency department and discharge planners)

❑ Social Service Providers

❑ Public Health Department

❑ Self-Referrals

❑ Internet/other advertising

❑ Word of mouth

❑ Other (Please Specify) _____

Q5 What kind of an assessment do you do with a patient/client to assess client needs when you get a referral? (Select all that apply)

❑ In-person assessment

❑ Phone assessment

❑ Neither

Q6 Please describe your in-person assessment

Q7 If you can share the in-person assessment with us, please upload a copy here.

Q8 Please describe your phone assessment

Q9 If you can share the phone assessment with us, please upload a copy here.

Q10 What are the specifications/restriction that patients/clients must meet to receive care/case management services in your program? (restrictions could be by age, e.g. seniors or children only; geography, e.g. Washtenaw but not Wayne county; type of disease, e.g. only those with diabetes; citizenship etc.)

Q11 What are the current gaps you see in the care/case management services offered in Washtenaw and Livingston counties?

Q12 Do you do any formal assessment of whether or not the patient/client is working with any other care managers?

○ Yes

○ No

○ Sometimes (please specify in what cases you do a formal assessment)

_____

Q13 How do you coordinate with other care managers at health systems, physician offices, social services providers, or other agencies?

Introductory

1. Many of us are meeting each other for the first time today and it'd be nice to get to know one another a bit before talking about serious subjects. How about we share our first name and a little something about ourselves such as a favorite memory with a family member or friend?

Experience at the ED

Now, we would like you to think back at your experiences visiting the emergency room over the last year.

1. Raise your hand if you have visited the Emergency Department (ED) in the last 12 months [Take a tally of the number of people who raise their hand at each interval]:

    a. 1 or 2 times

    b. 2 to 3 times

    c. 3 to 5 times

    d. 5 to 9 times

    e. 10 or more times

2. What was the reason you went to the ED?

    a. Probe: Did you think about going anywhere else? If so, why did you choose the ED?

        i. Suggestions include:

            1. PCP office was closed

            2. My doctor told me to go to the ED

3. I needed immediate attention that I wouldn't be able to get from my doctor.

3. What was your overall experience like?

   a. Probe: How did you feel after your visit?

   b. Probe: Were you satisfied/dissatisfied with the care you received?

4. After you left the ED, what happened?

   a. Probe: Did you have a plan of what to do after you left?

      i. If so, were you able to follow your plan?

      ii. What made it difficult or easy to follow?

   b. Probe: Did you talk with any other doctor or case manager about your ED visit?

      i. If so, tell us about those conversations?

   c. Did anyone at the ED follow up with you after your visit?

      i. If so, tell us about those conversations.

Case Management and Basic Needs

Now we're going to talk about case management and basic needs. A case manager is a person who helps you plan, coordinate, and advocate for options and services to meet you and your family's health needs through communication and available resources.

5. Raise your hand if you currently have a case manager or other representative who helps you navigate services that you need.

6. What are the types of things that you work on with your case manager? [*If someone does not have a case manager, modify the question to include things you would like help with*]

   a. Probe: What is the most important thing that you case manager has helped you with?

       i.   Probe: Do you have a care plan?

    b.   Probe: What are some things that your case manager does that you like?

    c.   Probe: Have you ever had trouble getting a case manager?

7. What is your case manager unable to help you with [e.g. housing, food]?

8. Where else do you go to get help for the things you need? [mention needs that people described above. Other examples include neighbor, DHS office]

9. Sometimes people go to multiple places to get their needs met. Raise your hand if you have more than one case manager or more than one person helping you with you with your needs.

    a.   Probe: Do your case managers ever talk to one another? If so, was that helpful for you? How did you feel about that?

Access to Care

10. Please raise your hand if you have a regular doctor or healthcare provider you see.

11. Raise your hand if you have you gone to that doctor within the last year.

    a.   If so, how many times did you go?

    b.   Does your doctor ever talk with your case managers/care coordinators?

Wrap-Up

We are just about done with this discussion. As we mentioned in the beginning, we are trying to understand how and why people access health care services, such as ED visits, and barriers to care. What advice would you have for us?

- Would you say more?

- What else would you recommend?

Closing Comments

- Thank you all very much for an insightful discussion on how you make health care decisions.

- We want to remind you all that this information is completely confidential.

- If you have any questions, comments, or concerns about anything that we discussed today, please do not hesitate to contact us.

Factions	Values	Potential Effects of Integration of Healthcare and Social Services through SIM	
		Potential Gains	Potential Losses
Members of SIM Target Population (Frequent ED Utilizers)	Compassion; Money; Expediency	Quicker referrals to appropriate resources; longitudinal relationship with lead case manager	Loss in familiarity of ED; loss of ability to move between providers;
Center for Healthcare Research and Transformation (CHRT)	Universal health coverage; Efficient operations and meetings; Evidence-based decision-making; community-based public health	Secured funding and increased reputation for CHRT; increased connections to hospitals, social services agencies; valuable experience working with multi-stakeholder projects;	Loss of control; loss of top-down operational view of leadership; loss of belief in insurers as mechanism to create sustainable change; loss of safety in navigating inter-sector inter-organizational politics;
WHI Steering Committee Members	Being a space for community health planning; advocating for health insurance access; filling gaps in health services in the community	Gain in being a space where community agencies come for funding; gain in reputation as a convener	Loss of independence (operating only in Washtenaw county); loss of control; loss of view that the people in the room know what needs to be done for low-

				income individuals
State Government	SIM	SIM Success; patient-centered care; community-driven processes		Loss in worldview (if SIM fails); loss in career ladder
	Medicaid	Achieving good patient outcomes for dollars spent; Staying within political bounds	Improved patient care; demonstrated care models;	Loss of support from state congress; loss of familiarity with services provided
Payers	BCBSM	Expand membership; Align incentives to reduce cost and provide quality healthcare	Reduced costs (if successful), without taking risks to invest in new services;	Loss of normal payment mechanisms; financial loss or loss in membership due to increased premiums; loss of worldview of "aligning incentives";
	Medicaid MCOs	Expand membership; Align incentives to reduce cost and provide quality healthcare; Fulfill obligations to the state	Reduced costs (if successful), without taking risks to invest in new services; gain experience working with mental health, be able to have argument to take on Medicaid mental health contracts	Loss of normal payment mechanisms; financial loss or loss in membership due to increased premiums; loss of worldview of "aligning incentives"; loss of operating at population level without knowing local context

Hospital Systems	Community Benefit Office	Provide financing and services to community organizations and community members; Champion community needs within the health system	Increased attention to their work; additional resources to complete their work	Loss of traditional method of operating through grant-initiatives; loss in power as population health moves into their realm
	Emergency Departments	Provide comprehensive acute care to patients with emergent conditions;	Improved mechanism for referrals; reduced in appropriate ED visits, which may lead to greater health provider satisfaction	Decreased revenue (and profit) from fewer ED visits; loss of the view that patients are not in their purview when they leave the ED; loss in familiarity with standard ED operations; loss of independence
	Primary Care Practices	Patient-centered care; Efficiency; patient satisfaction	Increased number of visits; better knowledge of social resources to serve their patients	Loss of independence; loss of view that they only work on medical issues; loss of time by spending more on addressing social needs and coordinating; loss of status
	Population Health Offices	Care Quality; Cost of care; integrating hospital departments	Experience experimenting with different care models	Loss of status as the site of "population health"; loss of control

	Complex Care Programs	Providing comprehensive care for the most challenging patients	Greater support from other care providers;	Loss of time; loss as the only provider for this population;
	Hospital Executives	Providing high quality patient care; maintaining financial stability; being a good steward to the hospital mission	Improved good-will in the community	Loss of money to health system; loss of reputation; loss of mission
IHA	Primary Care Practices	Patient-centered care; Efficiency; patient satisfaction	Increased number of visits; better knowledge of social resources to serve their patients	Loss of independence; loss of view that they only work on medical issues; loss of time by spending more on addressing social needs and coordinating
	Specialty Practices	Providing high quality patient care; patient satisfaction		Loss of prestige; loss of money
Health Centers	Packard Health	Provide comprehensive, primary care to low-income populations; address medical, mental health, and social needs of patients	Increased recognition for their previous work to integrate healthcare and social services; More resources to serve their patients	Loss of status of being the one of the only medical providers that links medical and social services; loss of independence
	Corner Health Center	Provide comprehensive, primary care to low-income youth; address medical, mental health, and social needs of patients; be responsive to community members	Increased recognition for their previous work to integrate healthcare and social services;	Loss of independence;

			More resources to serve their patients	
Public Health Departments	Washtenaw County Public Health	Health equity; community empowerment/development; health of county population	Improved community relationship for those serving the low-income; improved health of population	Loss of role as convener of public health entities
	Livingston County Public Health	Community input; health of county population	Increased resources to Livingston county; improved health of population	Loss of role as convener of public health entities; loss of independence from Washtenaw county
Mental Health Agencies	Washtenaw County Community Mental Health	Providing comprehensive services to patients	More resources to serve their patients; greater adoption of IT solutions they've work to develop	Loss of independence;
	Livingston County Community Mental Health	Providing comprehensive services to patients	More resources to serve their patients;	Loss of independence;
	Mental Health Partnership of Southeast Michigan	Disbursement of funding to successful mental health and substance use care models		Loss of funds; exclusion of some of its grantees
Washtenaw Health Plan		Provide health insurance and case management to low-income individuals; be responsive to the community; health advocacy	Recognized thought leader in low-income case management; Experience with community	Loss of status as the convener of low-income health-service organizations;

		health workers	
Avalon Housing	Provide supportive housing for the homeless; practice harm reduction and community empowerment	Increased recognition for their previous work to integrate healthcare and social services; Improved access to health system resources;	Loss harm reduction and community empowerment approach through engagement with the traditional medical system; Potential loss of model of providing grant-funded services without billing for them
Other Non-Profit Organizations	Being community-based;	Improved access to health system resources	Loss of independence from health sector;

Appendix V: Financial Cost Estimation

This estimation assumes a fee-for-service delivery model. The percent changes are simple estimates about what people think is reasonable to change in the SIM intervention. The number of people with five or more ED visits in a year in Washtenaw and Livingston counties is estimated to be 1,200 using data from the two health systems, MM and SJMHS. Due to the difficulty in obtaining this data from health systems, as well as the ability to share the data obtained, the cost from this estimation comes from estimates from Kaiser Family Foundation (Kaiser Family Foundation, n.d.) and from publically available Medicare data ("Medicare Hospital Spending by Claim," n.d.). Defining variable and fixed costs needs further clarity—as labor may be considered partially fixed, and partially variable.

	Present Cost	Present Revenue	Future Projected Costs	Future Projected Revenue	Change in (Variable) Costs	Change in Revenue
Emergency Department Visits	$19,399,478	$21,040,649	$18,752,829	$18,936,584	($646,649)	($2,104,065)
Inpatient ViVisits	$56,270,103	$101,813,688	$53,456,824	$96,723,004	($2,813,280)	($5,090,684)
Outpatient Visits	$892,182	$1,565,099	$802,066	$1,407,000	$11,072	$67,000
Case Management	$221,459	$469,000	$243,602	$515,900	$22,144	$46,900
Community Mental Health Visits with LiCSW	$0	$0	$0	$0	$0	$0
Other Mental Health Services	$0	$0	$0	$0	$0	$0
Totals	$76,783,223	$124,888,436	$73,255,321	$117,582,487	($3,426,714)	($7,080,849)

Detailed Estimates						
	Fixed Cost per visit	Variable Costs per visit	Revenue per visit	Average number of visits per person in 12 month period	Of People with 5 or more ED visits in previous 12 months in CHIR Region, # receiving services	Total Yearly Visits
ED Visits	$1,414	$707	$2,300	7.62	1200	9148
Inpatient Visits	$4,513	$6,769	$12,249	16.23	512	8312
Outpatient Visits	$76.00	$114.00	$200	11.05	708	7825
Case Management Visits	$24	$33	$70	67.00	100	6700
Community Mental Health Visits with LiCSW				0.00	500	
Other Mental Health Services				0.00	200	
Totals	$6,026	$7,623	$14,819	16.99		31986

Intervention Scenarios					
	Change %	New Yearly Visit #	Change in Number of Yearly Visits	Change in (Variable) Costs	Change in Revenue
Reduction in ED Visits	-10%	8233	-915	($646,649)	($2,104,065)
Reduction in Inpatient Visits	-5%	7896	-416	($2,813,280)	($5,090,684)
Increase in Outpatient Visits	5%	7035	335	$11,072	$67,000
Increase in Case Management Visits	10%	7370	670	$22,143.50	$46,900
Increase in Community Mental Health Visits with LiCSW	5%	0	0	$0	$0
Increase in Other Mental Health visits	5%	0	0	$0	$0

3/7/17

Proposed SIM Care Coordination Model

SIM
MDHHS State
Innovation Model

Assessment & Services Delivery

50% from predictive model randomized to control group

Data

Predictive model generates list of patients

Referrals from providers

Analysis

Administrative Hub

Central administrative hub uses patient data to determine appropriate "hublet" to assign resident

- Complete quality assurance tasks (e.g., ensuring data is being shared, following up on referrals)
- Convene cross-hublet coordination meetings

Community Hublets

Initial intake:

- Consent residents for intervention and obtain release of information
- Screen patients for existing relationships
- Determine appropriate lead entity

Coordination and Service Provision:

- Hublet/Lead Entity coordinates with partner entities and links clinical and social services
- Facilitated by a system that closes loop on appointments and referrals

PDCA Cycles[1]:

- Meet regularly in cross-entity meetings to discuss intervention challenges, complex cases or cases where appropriate services are not available in the community

Partner Entities
Work with Community Hublet and Lead entities to provide:

- o Wrap-around services for high risk patients
- o CHWs[2] provides linkages between medical and social services
- o Referral to peer support network for particular social/mental health needs
- o Provide linkage to Patient Centered Medical Home

1: PDCA Cycles will include hublets, partner entities, Medicaid Health Plans, Coordinated Funders, and other relevant organizations.

2. CHWs will be housed at the Washtenaw Health Plan, though they will work across hublets and partner entities.

Appendix VII: SIM Intervention Model Assumptions

The purpose of this document is to describe the elements of the SIM intervention, and to make our assumptions explicit so that we can check the validity of these assumptions first amongst the SIM co-chairs and CHRT staff, and later the with SIM Work Group and subcommittee members.

1. Overall Intervention Design and Capacity

Description: Approximately 2,000 individuals will be selected annually for the SIM Intervention. The majority will be identified using a model that predicts ED use in the next six months based mainly (at least initially) on demographic and clinical information received from: Michigan Medicine (MM), St. Joseph Mercy Health System (SJMHS), and IHA through Great Lakes Health Connect. In addition to those identified through the predictive model, other individuals will be referred to the intervention by community providers/agencies.

Assumptions

- 2,000 individuals and a six-month timeframe are sufficient to measure the expected impact of the intervention on ED visits and the health of those in the intervention group.

- We currently have the program funding and the community capacity to serve 2,000 individuals through the intervention.

2. Identifying Individuals for the Intervention

Description: The predictive model will be run monthly to identify 100-200 individuals per month with the highest numbers of expected ED visits. Provider referrals will be incorporated into the intervention as they come in. We know that

some individuals identified as high ED utilizers in one time period are likely to use ED services at a lower rate in a subsequent time period (the known "regression to the mean" issue).

Assumptions:

- Selecting participants based on the greatest number of expected ED visits will yield the best target population for our intervention.

- The intervention can actively manage 100 patients per month with the current systems capacity. The intervention will likely need to have a pilot phase, with a smaller number of individuals before we are able to manage 100 patients per month.

- The predictive model will be able to parse out who will use the ED frequently in the future, and those that will not, better than relying only on the knowledge of providers.

- We have sufficient funding to build and run the predictive model at this frequency.

- The data will have enough variation that the list of individuals the model produces will be different from month to month.

- MDC, MiHIN, and Great Lakes Health Connect will have sufficient capacity to send and receive new data necessary to run the predictive model monthly.

- In the first year, the predictive model will contain ED utilization data from Michigan Medicine and St. Joe's, possibly from June 1, 2016 to May 31st, 2017 due to the delay in receiving data from UofM's data warehouse.

- In the second year, outpatient data from IHA will be added into the predictive model.

- As additional data becomes available (e.g., from DHHS or social service agencies), we will be able to add that information into the predictive model.

- Providers will refer residents to the intervention based on yet-to-be-defined criteria. The providers will be able to send data on the resident to the hub. The data they will send has not yet been determined.

- We can set up a process to receive provider referrals for this intervention.

3.   Intervention Evaluation Design

Description: Half of the pool of individuals identified by the predictive model (approximately 100 per month) will engage in the intervention and the other half will be randomized to a control group and their entry in the intervention will be delayed 6 months. Those in the control group would continue to receive usual care during the delay. Those referred from providers would all be enrolled in the intervention without being randomized.

Assumptions

- The State will allow us to randomize our intervention enrollees.

- The MM and SJMHS IRBs will approve the intervention design and the health systems' compliance offices will approve the processes before we begin implementing the intervention in August 2017.

- The community will accept the design to delay the intervention for 6 months for some individuals while they receive usual care.

- Individuals will be randomized each time the predictive model is run at the hub.

- Once an individual is randomized to the control group, they are removed from the pool or participants who might show up in the predictive model the following month.

- Care managers and others implementing the intervention will be successful in reaching individuals in the control group after their 6-month delay to engage them in the intervention in a timely manner.

- A randomized control trial is the best method to evaluate the impacts of this intervention.

- Referrals from providers outside of the predictive model will not affect the validity of the evaluation design.

- Once the individuals who are delayed start getting services (after 6 months), do we will continue running the predictive model to identify additional people to enroll (e.g. enrolling approximately 100 delayed individuals and 100 newly randomized individuals for a total of 200 individuals per month)

4. Enrolling Individuals in the Intervention

Description: Once the required consent is provided and the initial assessment is completed at a hublet, individuals can be enrolled in the intervention. In its current design, the expectation is that few individuals identified through the predictive model or referred by providers would refuse engagement or be otherwise unable to participate in the intervention. Potential reasons for non-participation include: death,

lack of completion of the initial assessment, significant acute illness, movement out of SIM region, lack of consent, or data access issues (lack of contact info).

Assumptions

- Contact information available for most individuals will be accurate.

- Care managers or others will be able to contact individuals via phone or other information included in the data.

- No incentives will be needed to encourage individuals to enroll in the intervention. Individuals will want to enroll in the intervention and will have few barriers—such as time, transportation, ability to answer assessment questions, lack of trust.

- Individuals will respond best to those they already have a previous relationship with.

- If not previous relationships can be identified, individuals will be willing to work with a case manager or CHW with whom they have no previous relationship.

- In order to enroll in the intervention, individuals must sign a consent and release of information. The consent will include permission for the following: to review health information and insurance claims data, to share information across hublets and lead entities for care coordination, and to be randomized to the control group.

- Consent for release of information to all entities in the intervention can be completed in one sitting—possibly with one form.

- Individuals must also complete an assessment or screening to enroll in the intervention. The questions on this assessment, as well as where this data will be stored has not yet been determined.

5. Care Coordination Design

Description: Many individuals will engage with the intervention even though they are already connected to one or more community agencies. The intervention is designed to maintain these existing relationships and have the connected agency evolve into a "lead entity" for the individual's care (see below).

The individuals randomly selected for initial active management through the intervention will:

A. Have their data assessed by an intervention worker at the administrative Hub who will assign the individual to an appropriate "hublet." No exclusion criteria have been developed by the intervention work group yet.

B. Be contacted by the assigned hublet, which will obtain consent and release of information permissions, screen for existing relationships with providers and determine an appropriate lead entity based on previous relationships, geography, and the individual's primary needs. Some individuals may be excluded from the intervention at this point if they decline to participate in the intervention or if they are unable to complete the initial assessment within 3 months of referral (individuals may return to complete the assessment at another time, but the hublet will no longer seek to contact them).

C. Be assigned to a lead entity that will provide services and coordinate with other clinical and social service providers for the individual. An individual could be

excluded from the intervention at this point if the lead entity cannot contact them within 3 months of receiving the assignment, or if the individual requests removal from the intervention. Once assigned to a lead entity, individuals may be reassigned as their priorities and needs are better understood. Lead entities will work to create a shared care plan that can be shared with all relevant providers involved in the individual's care.

    a. Some individuals will be assigned a Community Health Worker (CHW) if they can benefit from home visits, additional education, or assistance with/accompaniment to appointments. CHWs will be supervised at one central location (likely the Washtenaw Health Plan), but they will often move around the region, with flexible office space at some lead entities in the counties.

D. Have their cases discussed and followed through bimonthly cross-hublet meetings so that providers can work together to reduce barriers to providing services, to ensure that care is coordinated across hublets and lead entities, and to identify gaps in services for individuals in the intervention. These cross-hublet meetings will be the venue for PDSA cycles, and recommendations for improvements in the SIM care coordination model will come from these meetings.

Assumptions

- Many/most individuals identified by the model or recommended by providers will already have some connection to area human service agencies but some will not be connected. (Most will already be known to the health systems because the predictive model uses health system data).

- The individual working in the Hub requires no clinical expertise.

- The Hub will identify existing relationships through MiHINs ACRs files, and through information collected from those that are referred to the intervention outside of the predictive model.

- There will be approximately 10 hublets, at least two of whom will be from ASCs. Hublets will be determined by participation in SIM meetings to-date, geographic distribution, as well as identified needs of the target population. Hublets will receive funding for their participation.

- Any organization can be a lead entity. here is no limit to the number of lead entities. Lead entities will not receive funding.

- Hublets and lead entities will be motivated to participate in SIM.

- The individual working in the Hub will communicate to all other entities which is the lead entity for each individual in the intervention.

- The data and means of recording data that hublet will be required to track on individuals and report to the hub has not yet been determined.

- Cross-hublet meetings will be opportunities for providers to discuss barriers and gaps in services.

- Gaps in services identified in cross-hublet meetings will be elevated to the WHI Steering Committee and Coordinated Funders.

- The CHW-supervising entity (likely WHP) will be able to hire, train, and supervise CHWs.

- CHWs will be able to become team members within multiple entities in the CHIR, while being supervised out of a central organization. They will have

office space, attend staff meetings and case conferences, and have access to medical/social service records.

- There will be criteria for which individuals are assigned CHWs.

Introductory Questions

1. Tell me about your role within the WHI.

   a. Probe: How regularly do you attend meetings? How much work do you outside of meetings?

   b. Probe: How satisfied are you with your role at WHI?

Defining a Common Agenda

2. Tell me about WHI's purpose.

   a. Probe: What are the problems WHI is seeking to address?

   b. Probe: Do the stakeholder members/the steering committee members* have a similar understanding of WHI's purpose? Please give me examples of some different points of view.

      i. Probe: Some of the comments of the WHI member survey suggested that WHI has shifted from its original mission focusing on low-income, uninsured individuals. What do you think about this shift?

      ii. Probe: Do you feel like you have ownership over WHI's agenda?

Mutual Reinforcing Activities and Data

3. Have there been any WHI projects that have been successful? If so, tell me about one.

   a. Probe: What made it successful?

4. Have there been any WHI projects that have been unsuccessful? If so, tell me about one.

   a. Probe: What lessons were learned from that project?

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* If conducting an interview with stakeholders, ask about other stakeholders. If conducting an interview with steering committee members, ask about other steering committee members. CHRT staff will be asked this question in regards to work group or project they have worked most closely with.

b. Probe: Have these lessons been applied to other projects?

5. One of the findings of the member survey was that WHI could improve measurement of its programs. Regarding the example projects you mentioned, how did those programs measure success?

   a. Probe: How could measurement of those programs have been improved?

6. The results from the survey suggested that the WHI has not reduced service duplication in Washtenaw County. Do you agree with this assessment? If so, how could the WHI work to reduce duplication of services in the community?

Continuous Communication

7. Results from the member survey and stakeholder meeting provided suggestion on improving communication by posting meeting minutes, and putting articles in the Ann Arbor observer, what do you think about these suggestions?

   a. Probe: If WHI improves its communications, what do you think will change with better communication? Is communication just another word for power?

   b. Probe: Some of the comments in the survey suggested that WHI project should involve consumers (such as opioid users and their family members) more in its activities. Tell me your thoughts on this idea. How could WHI do this?

   c. Probe: Steering Committee makeup and process

   d. Probe: Engaging diverse members

8. In the context of WHI meetings, can you tell me about a time where there was a disagreement and how it was resolved?

   a. Probe: Do people feel comfortable challenging each other?

Backbone Support Organizations

9. What are the opportunities for collaboration between the medical and social service

    sector with the SIM project?

    a. Probe: What opportunities are there specifically to increase engagement of new

        organizations?

10. What are the challenges you see of working between the medical and social service sector

    with SIM project.

11. How can WHI's work be sustained going forward?

    a. Probe: What do you think about each of these options?

        - membership fees

        - community benefit funds

        - shared savings or global payment contributions

        - state-mandated or voluntary support from ASCs

        - public funding

        - social investing

        - community development financing

Final Questions

12. How should the results from these interviews be disseminated to the stakeholders?

13. Do you have anything else to add?

Membership

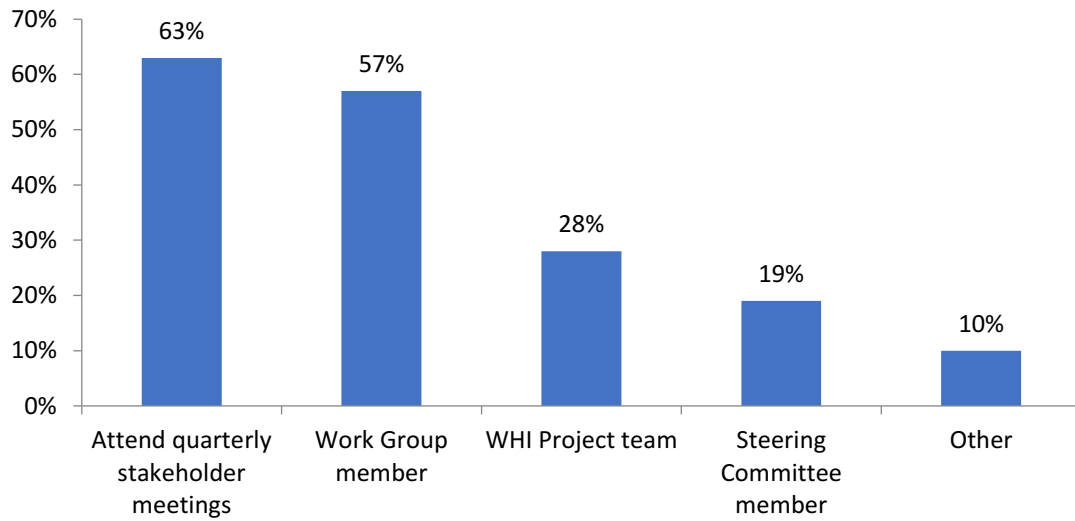**The majority of respondents were WHI members for 1-4 years, attended quarterly stakeholder meetings, and were members of a work group.**

How long have you as an individual been a member of the WHI?

	Percent
Less than 1 year	19%
1-4 years	**53%**
5 or more years	28%
Total	100%

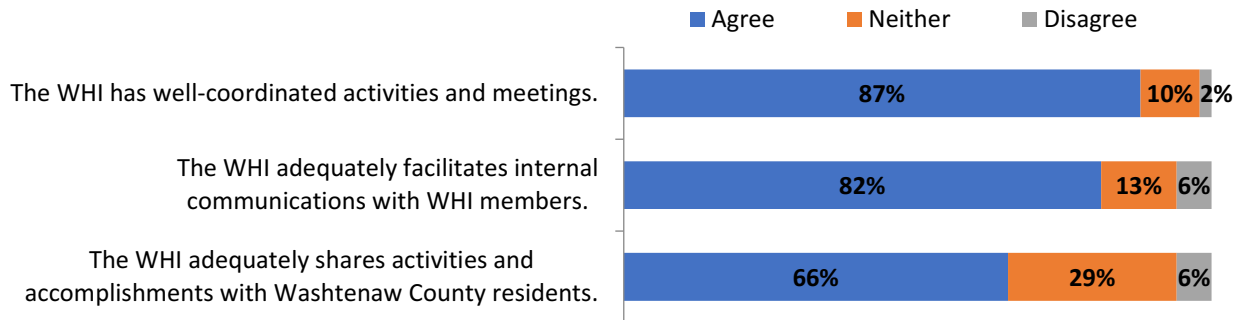*Please describe your individual level of involvment with the WHI:*

Respondents felt that overall, the WHI has well coordinated activities and meetings, and adequate internal communications with WHI members.

To what extent do you agree or disagree with the following statements…

Legend: ■ Agree ■ Neither ■ Disagree

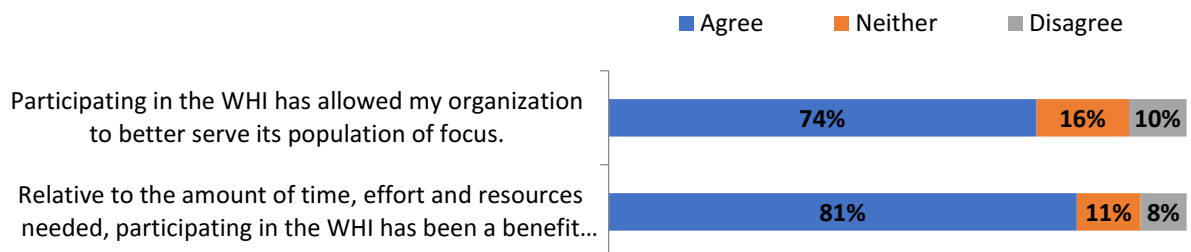| Statement	Agree	Neither	Disagree
The WHI has well-coordinated activities and meetings.	87%	10%	2%
The WHI adequately facilitates internal communications with WHI members.	82%	13%	6%
The WHI adequately shares activities and accomplishments with Washtenaw County residents.	66%	29%	6%

However members did identify areas for improvement, including: greater transparency of the Steering and Finance Committees, increased reporting on workgroup activities, and increased messaging to Washtenaw County residents. Additionally, one respondent identified the need for greater recognition of the time that small organizations contribute to the WHI.

- *"There have not been any recorded minutes from Steering Committee meetings, and no workgroup minutes provided to the steering committee. This impedes internal communications."*
- *"Would be nice to get more reports of workgroups activities, apart from annual report."*
- *"Seems like communication and discussion among those of us in WHI or the health care and social system is good. Not convinced it is widely understood by governmental bodies and the residents of Washtenaw [County]."*

Effectiveness

Overall, WHI members feel that participation in the WHI has been a benefit to their organization, and improved their organization's ability to serve their focus populations.

To what extent do you agree or disagree with the following statements…

Legend: ■ Agree ■ Neither ■ Disagree

Statement	Agree	Neither	Disagree
Participating in the WHI has allowed my organization to better serve its population of focus.	74%	16%	10%
Relative to the amount of time, effort and resources needed, participating in the WHI has been a benefit…	81%	11%	8%

Respondents also felt that participation in the WHI allows member organizations to better respond to the needs of the community in addition to other measures of effectiveness.

However, the ability of the WHI to to help member organizations implement and measure the effectiveness of programs to address specific commuity health problems may be a potential area for improvement.

As a result of participation in the WHI, is your organization better able to…

Legend: ■ Yes ■ No ■ No opinion

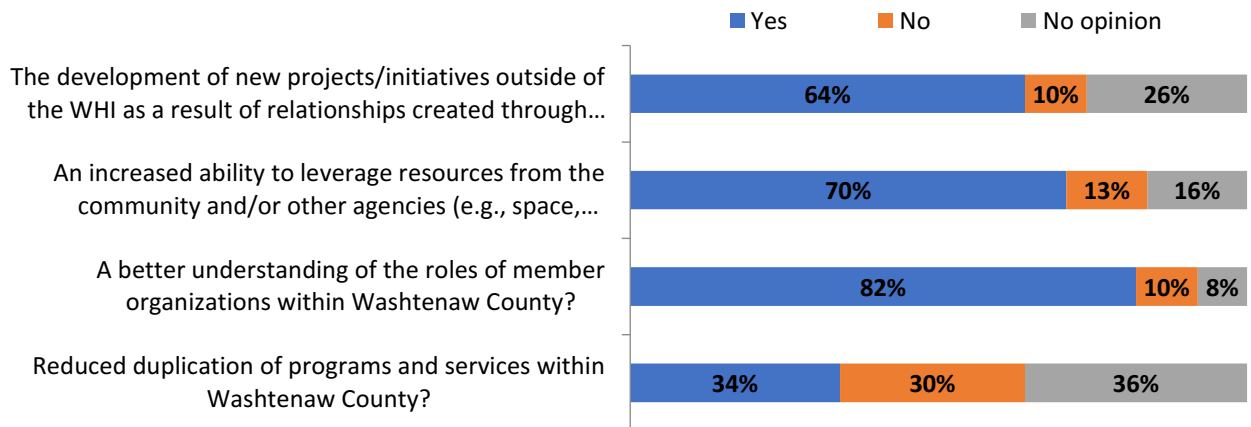| Question	Yes	No	No opinion
Respond to the needs of Washtenaw County better than your organization could by working alone?	84%	6%	9%
Carry out activities that connect multiple services, programs or systems?	80%	9%	11%
Measure the effectiveness of programs to address specific community health problems?	52%	14%	34%
Implement programs to address specific community health problems?	63%	16%	22%
Determine whether specific community health problems can be feasibly addressed through collaborative programs?	78%	8%	14%
Define the size and scope of specific community health problems?	77%	6%	17%
Identify priorities for addressing community health problems?	75%	13%	13%
Develop new or creative ways to identify and address community health problems?	70%	13%	17%

Members cited various needs assessments and the launch of the first combined community health needs assessment (CHNA) as indications of the effectiveness of the WHI. However, one respondent indicated that while they perceived the work of the WHI as useful, the impact of projects, because most are small pilots, not be significant.

- *"Because of the WHI, UMHS and St Joe's will for the first time do a combined CHNA and set the stage for a coordinated response to community needs. It also allowed us to land the SIM phase 1 pilot, and to apply for the AHC. Personally, it helps me learn about the underserved in our community, their needs, and how we can help meet their needs."*
- *"I used what I've learned in WHI committee meetings to advocate for projects relating to certain populations and health care topics."*

Coordination and Collaboration

Overall, members felt that the WHI has increased understanding of the roles of member organizations within the county, increased ability to leverage community resources, and the generation of spin-off projects. However, only 34% of respondents felt that the WHI has reduced duplication of programs and services within Washtenaw County, suggesting a potential area for improvement.

As a result of collaboration through the WHI, is there…

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Legend: Yes, No, No opinion

	Yes	No	No opinion
The development of new projects/initiatives outside of the WHI as a result of relationships created through…	64%	10%	26%
An increased ability to leverage resources from the community and/or other agencies (e.g., space,…	70%	13%	16%
A better understanding of the roles of member organizations within Washtenaw County?	82%	10%	8%
Reduced duplication of programs and services within Washtenaw County?	34%	30%	36%

Respondents particularly cited the work of the Opioid project as an example of successful collaboration within the WHI.

- *"The Opioid group has been quite active and collaborative. Participation in that group has contributed the most to the above answers. It is not clear to me if collaboration (outside of the opioid group) is necessarily as a result of WHI or would happen regardless."*
- *"As a provider of overdose prevention services, participation in the WHI Opioid Project has helped coordinate efforts with other service providers for more impact and County staff have been critical in helping provide data and monitor trends."*

However, respondents did identify the duplication of efforts that has occurred through the work of the WHI.

- *"In some respects the WHI has duplicated efforts. For example, starting an assessment of senior services without first connecting with the coordinated funding senior group is an example of duplicating efforts. This has the potential to undercut existing community collaborative efforts."*
- *"The WHI moves into areas where there is already community planning with little understanding of or coordination with current planning efforts. This has almost always resulted in duplication of efforts. [In my opinion], the WHI attempts to take credit for other agencies' work-- this is fatal to constructive collaboration.*

Additionally, members felt that relationships established through WHI membership have generated a number of spin off projects including the implementation of the Washtenaw Recovery Advocacy Project (WRAP), and the success of the State Innovation Model (SIM) application.

- *"As a result of the Opioid Project Washtenaw Recovery Advocacy Project (WRAP) was developed and implemented. WRAP is Recovery Community Organization that supports recovery, educates the community regarding addiction and recovery in an effort to reduce stigma. In addition WRAP works at the local and state level to advocate for policy enhancement regarding addition treatment and recovery."*
- *"Unified is providing HIV and [Hepatitis] C testing at the Ann Arbor Treatment Center."*

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- *"The state's SIM application (Blueprint) is to some extent a WHI spinoff. They modeled the CHIR and backbone after the progress coordinating underserved needs in WC."*

"We have partnered with WHP to bring enrollment assisters to our community/agency on a regular basis to supplement the benefits enrollment we are able to offer to clients on our own."

These are quotations from in-depth interviews which are relevant to finding described in the results section. They were omitted to improve the flow the dissertation, but may be of interest to those seeking to understand some of the quotations behind what is described in the results.

A. The WHI's Most Salient Agenda is Promoting Community Connections

It is a relief to be a part of the WHI….We could make very little headway [previously] …The WHI provides this platform and we've been able to have conversations, and a level of transparency across organizations that has really been a major phase shift, a sea change. –Steering Committee Member

One of our active IV heroin users shared with us last week that he can only purchase heroin that he reports tastes differently and that is taking 3-4 doses of Narcan to reverse when he uses and he's a very heavy user. Which tells me it could be carfentanil. Pre- Opioid Project, I wouldn't even know what to do with that information, other than warn everyone who I know who is using. Now, I call [health department employee name], and say "What can we do here? This is what I'm hearing." Those networks become lifesaving. -Project Member

I didn't perceive much duplication of programs and services to begin with; the gaps are more obvious, say, for example, the [Community Mental Health] folks who lost coverage. The public health department was already working with community nonprofits via the Health Improvement Plan to identify community priorities and share resources. The benefit to us is in being informed about grants and initiatives that affect county-wide service delivery. -Survey Comment

[Prior to 2014, all our projects] were focused on understanding why individuals who had access, or didn't have access—What were some of the barriers to them obtaining access under the original Medicaid rules? And now with the expansion, what were we going to be able to do to effectively provide services to that population? So when I say "morphed," when we get past January 2014, we then took on other issues, such as mental health [and] obesity. Later on we had the opportunity to address the opioid issue [and] advanced care planning. Those go beyond the ACA, in response to what the stakeholders identified as a continued need for a planning group, such as the steering committee of the WHI, or the WHI, to facilitate the types of conversations, around the delivery of healthcare to our community. -Steering Committee Member

The focus on the SIM introduces a potential challenge of maintaining a mutual understanding of what the WHI is. Understandably, we've taken the SIM project in under the umbrella of the WHI. The steering committee will understand it's role in governance for the SIM, but also still have this focus on the low-income, underinsured, uninsured population for the county. The fact that we've also expanded to Livingston County will challenge us at times, understandably, and even the name 'Washtenaw', by itself may be a limiting factor under SIM. -Steering Committee Member

We are now, a receiver of money, that we will distribute in some form or another. So now all of sudden, we're in a role, where we have to make choices and we may have competing interests for those choices. So that might change the landscapes…Probably more so than average, WHI needs to be extremely clear, and extremely transparent and extremely clear as to why it's doing

what it's doing…You want to be very transparent, very inclusive, and then you want to have a

clear criteria of why we're doing what we're doing—more so than a traditional organization.

Almost quasi-governmental. – Steering Committee Member

B. The WHI's Strengths and Weakness Reflect Those of the Backbone Organization

[CHRT Staff] will work with those members and other people outside of WHI too, to get that

information and do that analysis and report. Then we'll bring that back to the Work Group and

they'll give us feedback and ask us questions and help shape that report. So, it's not just a CHRT

staffer doing the whole project, [but] it can be driven by them. -CHRT Staff Member

I get pulled into consulting projects, which can be very time intensive. I would say, typically

with those, unless I have intern support, sometimes it does push my capacity to support WHI

projects…Just being able to stay up with all the tasks. It might be creating materials well in

advance [of meetings] or doing additional follow-ups. -CHRT Staff Member

C. Cultivating Member Engagement of a Maturing Coalition Requires Clear Structures and
   Intentional Facilitation, Which Are Not Always Present Throughout the WHI

There is clearly a functioning small executive group…[They] do a fair of strategic planning and

figure out how to present that to the group. I am assuming that is going on and I think it's a

good thing. That's another way they maintain effectiveness. –Steering Committee Member

There are three forms [of communications]. There are reports that CHRT staff writes. Those

flow both ways. They flow up to WHI. There are face-to-face presentations where I attend WHI

[steering committee meetings] …Then there's CHRT staff, that live beyond the WHI, so there can

be second order informal stuff. The staff is influenced by WHI, and the staff influences the

project, just by shaping what's done…There is no direct reporting or counseling. You're accountable to a club. –Work Group Chair

You wouldn't want the steering committee, this smaller group, to be functioning in a bubble. And I don't think they do, but the stakeholder group helps hold them accountable. –Work Group Chair

If you have a task and you want people to get involved because they need to be empowered to take it on, then I think that's where the co-chairs need to go in [and assign task]…It's okay for CHRT members to assign task…I think it has more of an authority if it comes from the co-chairs. -CHRT Staff Member

D. Goals, Measurement, and Activities Should Align with a Coalition's Purpose

We use [data] along the way to tweak what we were doing. We used it along the way to tweak how we collected information. There were times that it was clear I needed to go back and talk to docs at the ER again about how they were doing some things….It raised as many questions as answers…We were all shocked about how many people didn't follow through on this easy, free accessible care. -Project Member

When I was asked to do this, I thought it's a project with a very low probability of success, but it would be very meaningful if it worked and if it didn't work, it might leave enough residual that at another time, at another place, enough people would be touched that it could be reassembled, it would work.-Work Group Chair

E. Community Engagement is Slow, Challenging, and Necessary

One of the things that makes [community engagement] successful is that you're picking folks who embrace the role of advisor, rather than advocate, who can appreciate the complexity of the issue…Having someone there who is willing to have that dialogue, but present a perspective that may not be in the room. -Work Group Chair

In mental health care, there is a very high rate of no shows for visits, even just therapy or psychiatry. I remember we had this whole discussion of what are the reasons. To me, it was like, there should just be a couple of people in [the mental health work group] who don't go to their appointments to tell us why they don't go to their appointments. -CHRT Staff Member

We have a consumer advisory board, but it has taken a while to get established, and to really engage consumers on a regular basis. At the same time, we've had a lot of success with it. Consumers don't want to take time to participate in the consumer advisory board if they're opinions and thoughts are not truly going to be valued and listened to. From the outset, there has to be a way to show what impact this consumer group could have. -Project Member

F. The WHI Is Viewed Differently by Those in the Healthcare Sector and Those Primarily in the Social Service Sector

I hope the hospitals would focus some of our community support toward these areas if WHI wasn't there. Just may not be as focused, organized and leveraged which is the value WHI helps bring. And the involvement of others as well…WHI makes us 'smarter' on some of the healthcare and social determinants work. -Steering Committee Member

Philosophically, are they [the provider organization] aligned to do what it takes for this population [of frequent ED users]. Because you're gonna have to be willing to pay witness to high-risk behavior, you're gonna have to have skilled staff. Working in an inpatient setting is very different from working with people who use heroin in front of us. We have a very harm reduction approach that is absolutely necessary to disarm these folks. -Project Member

My big concern with it becoming a non-profit is are you going to go after the same money that Faith-in-Action in Chelsea is going after? Are you going to go after the same money that JFS is using to resettle refugees? – Work Group Chair

ACA	Affordable Care Act
ACO	Accountable Care Organization
BCBSM	Blue Cross Blue Shield of Michigan
CBPR	Community Based Participatory Research
CCAT	Community Coalition Action Theory
CHIP	Community Health Implementation Plan
CHIR	Community Health Innovation Region
CHNA	Community Health Needs Assessment
CHRT	Center for Healthcare Research and Transformation
CHW	Community Health Worker
CMMI	Center for Medicare and Medicaid Innovation
CMS	Center for Medicare and Medicaid Services
DSH	Disproportionate Share Hospital
DELTA	Doctoral Engagement in Leadership and Translation for Action
ED	Emergency Department
FUSE	Frequent Users System Engagement
HUB	Pathways Hub Model

IDI   In-Depth Interview

IHA   Integrated Healthcare Associates

IRB   Institutional Review Board

MM   Michigan Medicine

MMCO   Medicaid Managed Care Organization

MiPCT   Michigan Primary Care Transformation Project

MSSP   Medicare Shared Savings Program

PCMH   Patient-Centered Medical Home

ROI   Return on Investment

SIM   State Innovation Model

SJMHS   St. Joseph Mercy Health System

SMART   Specific, Measurable, Achievable, Relevant, and Timebound

SROI   Social Return on Investment

TaMMS   Tailored Mental Health Management Support for Primary Care

WCCMH   Washtenaw County Community Mental Health

WHI   Washtenaw Health Initiative

WHP   Washtenaw Health Plan