



Advancing Health Equity Through Multi-Sector Collaboration

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ADVANCING HEALTH EQUITY THROUGH MULTI-SECTOR COLLABORATION

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ABSTRACT

This doctoral thesis, *Advancing Health Equity Through Multi-Sector Collaboration*, highlights the need for multi-sector collaboration to address current health inequities. It is focused on three separate projects based in three distinct sectors, which included: local government, a primary care association, and a collaborative focused on creating partnerships and elevating data, policies and practices that promote health equity. The methods employed to better understand the difficulty of facilitating a cohesive multi-sector collaboration and achieving successful outcomes included a survey, a set of interviews, and an assessment of the literature on the effectiveness of policies and programs to improve health opportunity. Although the project goals for each organization differed, collectively they provided insights into the challenges presented when building a multi-sector collaboration, and allowed for the identification of the necessary elements that enable the success of multi-sector collaboration to advance health equity. This doctoral thesis highlights current knowledge on multi-sector collaboration in policy and in public health, delineates the goals, methods and findings based on the three projects and concludes with considerations towards achieving multi-sector collaboration to advance health equity.

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INTRODUCTION

Health equity is a public health concept that is defined as every individual having a fair opportunity to be healthy (Braveman, Arkin, Orleans, Proctor, & Plough, 2017). It has particular relevance for marginalized groups or groups that have endured discrimination—such as people of color, people living in poverty, people with disabilities, religious minorities, LGBTQ individuals, and women—and who have borne an unequal share of environmental and social burdens that have led to poor health and shortened life-spans. To achieve health equity, all individuals, regardless of their social and demographic characteristics, such as race/ethnicity, socioeconomic status among other factors, must have an equitable opportunity to live a healthy life (Braveman et al., 2017). Although this concept seems fairly simple, achieving health equity is an extremely complex undertaking, and health inequities are implicated in many of the disparities in health outcomes that exist today.

The root causes of health inequities are, “...intrapersonal, interpersonal, institutional, and systemic mechanisms that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender expression, and other dimensions of individual and group identity,” also described as “...the unequal allocation of power and resources – including goods, services, and societal attention – which manifest in unequal social, economic, and environmental conditions, also called the social determinants of health” (National Academies of Sciences, Engineering, and Medicine [NASEM], 2017, p.99). For example, negative health outcomes are more common among people burdened by a lower socioeconomic position, or a lack of adequate resources, among many other social factors (Baker, Metzler, & Galea, 2005). Social determinants of health often play a greater role in an individual’s health and consequent life expectancy than access to clinical care. In fact, clinical care alone has only an

estimated 20% impact on an individual's health and life expectancy, while other socioeconomic and environmental factors have an estimated 50% impact on health and life expectancy (Institute for Clinical Systems Improvement, 2014). Despite the critical need to address the root causes of health inequities, this remains a wicked problem; one that is intractable, involves many sectors and does not have a single or simple solution.

Because of the complexity of causes and possible solutions, reducing health inequities requires a multi-sectoral approach with a focus on traditional and non-traditional determinants of health. And because these determinants can vary from community to community, there is no single clear-cut approach that will be replicable everywhere. Improvements in health equity will also require collaboration and participation of sectors for which health may not be a priority, which presents an additional challenge (Glouberman, & Zimmerman, 2002).

For my doctoral thesis, I worked with three organizations, all of which were using a multi-sectoral collaborative approach to focus on different aspects of advancing health equity. This provided three distinct projects that offered different lenses for understanding and responding to this complex problem.

The first project was based in a Department of Health for which I conducted qualitative research on perspectives on health equity among community stakeholders. The second organization was the California Primary Care Association (CPCA). In this project I conducted qualitative research to help develop a strategic plan for their National Health Center Immigrant Workgroup. Finally, I worked with the National Collaborative for Health Equity, an organization based in Washington, District of Columbia, and researched and wrote policy briefs on various factors that influence health opportunities.

In this thesis, I will first discuss health equity in greater depth, including its importance as a public health issue, and the need for a multi-sectoral collaborative approach to alleviating the complex web of the social and environmental factors that contribute to poor health outcomes. The framework applied to my approach is that of a wicked problem, a problem for which there is no single or simple solution.

This is followed by an analysis of the literature on multi-sectoral collaborative approaches, and then a detailed presentation of my research and findings from my three projects, followed by recommendations and a conclusion.

THE VALUE OF HEALTH EQUITY

Some communities and neighborhoods have offered limited opportunities to their inhabitants for many generations, leading to stark differences in health outcomes. For example, populations living in neighborhoods five miles apart can have up to a 20-year difference in life expectancy due to differences in education, income, the quality of housing, and residential segregation. These types of structural inequities can play such a pivotal role in health outcomes that a person's zip code may be a greater predictor of health than a person's genetic code. Such differences affect a person's ability to be healthy "from womb to tomb." For instance, graduating from high school has a significant impact on life expectancy, as it affects employment and income opportunities throughout the life course. The fact that high school graduation rates vary dramatically by race/ethnicity and class, results in vast disparities in opportunities among groups with different graduation rates (NASEM, 2017).

Because achieving health equity is such a complex endeavor, it should be conceptualized as both a process and an outcome (Braveman et al., 2017). Although the goal is to eliminate health inequities entirely, reducing health disparities is another important measure of progress.

Improvements in social determinants of health, particularly among people who have been historically marginalized, can result in additional positive externalities, such as greater economic prosperity or increased happiness in these groups.

HEALTH INEQUITY – A WICKED PROBLEM

Health inequity, like many other social issues, can be considered to be a wicked, intractable problem. These types of social issues frequently occur in “interconnected networks of systems” in which it is difficult to determine the source of the problem, and “where and how we should intervene.” In fact, intervening anywhere in the network can have unintended repercussions and lead to even greater problems elsewhere. Defining the problem, locating the source of the problem, and identifying appropriate actions to resolve the problem are extremely challenging, often intractable problems themselves. This is due to the fact that “the kinds of problems that planners deal with – societal problems – are inherently different from the problems that scientists and perhaps some classes of engineers deal with. Planning problems are inherently wicked” (Rittel & Webber, 1973, p.160). Thus, societal problems are inherently wicked due to interconnection of root causes that disallow the identification of concrete solutions.

Wicked problems have distinct characteristics, each of which applies to attempts to eliminate health inequities (Rittel & Webber, 1973):

1. **A wicked problem has no concrete solution or end to the problem.** When a project that seeks to address a wicked problem ends, it is usually because there are insufficient resources to continue the project, or because the appropriate solution within the limitations of the project was implemented, not because the problem was entirely resolved (Rittel & Webber, 1973). Eliminating health inequities is challenging because it is difficult to identify the solutions. Further, as one aspect of inequity is resolved or

reduced, a new contributing factor can arise. As described earlier, improving health equity should also be viewed as a process and not just an end goal.

2. **Whether a solution to a wicked problem was effective or ineffective is not immediately discernable.** Solutions to wicked problems “generate waves of consequences over an extended – virtually an unbounded – period of time” (Rittel & Webber, 1973, p.163). The consequences of an implemented solution are not determined until such waves have run their course and influenced all potential individuals (Rittel & Webber, 1973). Thus, measuring the impact of an intervention or potential solution will take time.
3. **All wicked problems are unique.** Although problems can have similarities, they will all have unique characteristics (Rittel & Webber, 1973). The definition of health equity varies by community, context and sector, and although they may share similarities across contexts, solutions cannot be entirely replicated from one situation to another.
4. **A wicked problem is a symptom of a “higher level” problem** (Rittel & Webber, 1973). Health inequities or disparities in health outcomes among groups are often a symptom of underlying structural inequalities, and are caused by a complex interrelationship of root causes.
5. **Wicked problems can be explained in many different ways and their definition is largely dependent on the proposed solution** (Rittel & Webber, 1973). Just as health inequities are interpreted differently depending on the context, the proposed solutions will also influence the way in which the problem is defined. The relevant stakeholders may have very different values, priorities, and desired outcomes, all of which will influence how they describe and approach the problem. Health inequities are difficult to

address because they require the collaboration and participation of many different stakeholders with different values and priorities, including many who operate outside of the realm of healthcare. Priorities among sectors are not only different, but they may be in opposition with one another, or competition with one another for resources or to reach a desired objective.

In summary, health inequities, like many other social problems, are intractable, wicked problems, meaning that there is no one clear or right way for achieving health equity, and what is effective in one location may not be applicable in another. Additionally, health outcomes and health inequities are influenced by different stakeholders and sectors outside the immediate health sector. Therefore, multi-sector collaboration is critical both to fully grasp and understand the problems, as well as to identify solutions that will be most effective.

MULTI-SECTOR COLLABORATION TO ADVANCE HEALTH EQUITY

Advancing health equity requires changes in the unfair social conditions that lead to health inequities. This includes the removal of, "...obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care" (Braveman et al., 2017, p.2). Thus, to advance health equity it is necessary to "change and implement policies, laws, systems, environments and practices" to equalize the opportunities and resources for health (Braveman et al., 2017, p.7). Health is influenced by many factors that cut across multiple sectors which the healthcare sector alone cannot influence. Nonetheless, health continues to be largely perceived within the context of access to health care services, which though important, is not the sole, or even primary, determinant of health outcomes. Therefore, multi-sector partnerships are necessary to create the social and environmental conditions that can advance

health equity, including sectors for which health may not be a priority (Glouberman & Zimmerman, 2002).

LITERATURE ON MULTI-SECTOR COLLABORATION

Multi-sector collaboration is viewed as critical for addressing some of society's most complex problems, such as managing health disparities or closing the educational gap that arises from differences of income or race, among many others (Bryson, Crosby & Stone, 2006). This awareness of the interconnectedness of issues has led to the development of many frameworks for collaboration across sectors, and varied terminology to describe such collaborative work. For the purpose of this project, the terms "multi-sector collaboration," "cross-sector collaboration," "intersectoral collaboration," "partnerships," and "networks" will be used interchangeably to reflect the language used by various authors in this area of study.

ORIGINS OF MULTI-SECTOR COLLABORATION LITERATURE

Much of the literature on multi-sector collaboration comes from the fields of social science, public management, and organizational behavior, and is based on finding ways to manage differences. In a world in which conditions are turbulent, organizations often become interdependent, and actions in one sector can lead to unwanted consequences in another. This has led to a greater desire across multiple sectors to learn how to work together on a common issue (Gray, 1989). One such method is known as cooperative interorganizational relationships (IORs); the earlier literature about cooperative IORs focused on issues such as uncertainty about the future, and about the level of trust among actors, and helped shape the current literature on multi-sector collaboration (Ring & Van de Ven, 1994; Bryson, Crosby & Stone, 2015). More recently, however, literature highlighting both the value of multi-sector collaboration and frameworks for its integration into other fields, including public health, has emerged.

MULTI-SECTOR COLLABORATION

Different fields have conceptualized the need for multi-sector collaboration in unique ways. Some of the frameworks utilized to understand multi-sector collaboration in this section include, Bryson et al.'s (2006) Framework for Understanding Cross-Sector Collaboration, Emerson, Nabatchi & Balogh's (2012) Integrative Framework for Collaborative Governance, and Innes and Booher's (2018) theory of Collaborative Rationality, among others. Though different, most frameworks incorporate key features necessary to initiate multi-sector collaboration as well as to enable the success of multi-sector collaboration.

Table 1: Features of Multi-Sector Collaboration

Features	Summary Description
Interdependence	Multi-sector collaboration requires individuals that need one another to reach their objectives.
Problem Definition	All parties must share a common understanding of the problem.
Leaders and Sponsors	Multi-sector collaboration requires leaders and champions to initiate the work and encourage others to get involved.
Incentives	Incentives can be both positive and negative. For example, they can include immediate problems and resource needs, as well as new funding opportunities.
Good Governance	Structures and processes that enable shared decision-making.
Diverse Stakeholders	Individuals with diverse perspectives and from diverse sectors, including people affected by the problem.
Internal Legitimacy	Internal legitimacy is characterized by an inclusive and transparent decision-making process in which stakeholders have a shared understanding and trust.
Accountability	Accountability to one another and to the process is necessary for stakeholders to move multi-sector collaborative efforts forward.
Adaptiveness and Ambidexterity	Multi-sector collaboration requires adaption to new information and changing conditions. As well as the ability to successfully address tensions and conflict.

Multi-sector collaboration typically involves sectors that need to work with one another to reach their desired objectives, making collaboration essential. Collaboration can be defined as:

...a process in which autonomous actors interact through formal and informal negotiation, jointly creating rules and structures governing their relationships and ways to act or decide on the issues that brought them together; it is a process involving shared norms and mutually beneficial interactions. (Thomson & Perry, 2006, p.23)

Unlike cooperation and coordination, however, collaboration represents a long-term process to implement solutions in harmony, by engaging "...parties who see different aspects of a problem...constructively explore their differences...[and] search for solutions that go beyond their limited vision of what is possible" (Thomson & Perry, 2006, p.20; Gray, 1989). In the literature, many authors articulate that collaboration should be viewed as cyclical and constantly evolving to achieve the desired outcomes (Thomson & Perry, 2006).

Bryson et al. (2016), define cross-sector collaboration as: "...the linking or sharing of information, resources, activities, and capabilities by organizations in two or more sectors to achieve jointly an outcome that could not be achieved by organizations in one sector separately" (p.44). Cross-sector collaboration arose as the means to address some of the most complex problems that specific sectors or organizations could not address on their own, including some of society's most difficult and intractable problems (Bryson et al., 2015; Morse, 2010).

Gray and Purdy (2014) define cross-sector partnerships as: "...dynamic interactions of voluntary participants around shared interests, which stand in contrast to relationships constructed around purely contractual exchange relationships in which one party provides services for another" (p.205). The authors explain that cross-sector partnerships are based on collaborative or network relations, in which partners engage in joint information sharing and/or a set of actions that are not purely transactional in order to achieve a desired outcome. Meanwhile, Bingham (2008) describes such cross-sector interactions as a form of governance that involves

“...multiple organizations and stakeholders from public, private, and nonprofit sectors that combine in a network to address a common and shared problem” (Gray & Purdy, 2014, p.205; Bingham, 2009). The notion of collaborative governance further articulates this point.

Collaborative governance is described as “a governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus-oriented, and deliberative and that aims to make or implement public policy or manage public programs or assets” (Ansell & Gash, 2008, p.544). Networks for multi-organizational governance are also perceived as leading to public-private sector coordination, increased knowledge, efficiency and capacity necessary for addressing complex problems (Provan & Kenis, 2008).

Although collaboration is a term that is often used to refer to diverse work processes, successful collaborative processes are typically those in which experts work alongside individuals with local knowledge to create a joint understanding of their challenges and creative ways to address them. Collaboration, if implemented appropriately, can lead to the notion of *collaborative rationality* in public policy. Collaborative rationality is considered an effective way to address complex problems while also fostering collective learning, which allows communities to become more adaptive and resilient. The premise is, that in the context of addressing a wicked problem, an ideal solution does not exist, necessitating a diverse set of actors to engage in dialogue around their experiences, knowledge and ideas to come up with potential ways to begin to address the problem (Innes & Booher, 2018).

NECESSARY ELEMENTS FOR THE INITIATION OF MULTI-SECTOR COLLABORATION

Organizations and sectors typically decide to engage in cross-sector collaborations because they have failed in succeeding independently. Organizations will either engage in

collaborative work if they cannot achieve success on their own, or because collaboration is presumed to be the “Holy Grail of solutions,” or the ideal approach to resolving all issues irrespective of the issue or necessity to collaborate (Bryson et al., 2006). It is worth noting, however, that not all social problems require multi-sector collaboration to be successful. Heifetz, Kania & Kramer (2004) categorize problems as technical or adaptive. Technical problems are those that are well-defined, with known solutions based on adequate expertise, and organizational capacity. When a technical problem presents itself, the cost, organization(s) to be funded, and the outcome are pre-determined. An adaptive problem on the other hand, is a complex social problem, also described as a wicked problem. “Adaptive problems require innovation and learning among the interested parties and, even when a solution is discovered, no single entity has the authority to impose it on the others” (Heifetz et al., 2004, p.25). Adaptive problems cannot be solved using technical tools, and require all necessary stakeholders to engage in solving the problem for a solution to emerge (Heifetz et al., 2004).

Despite the importance of cross-sectoral collaborative efforts for addressing intractable public issues, this process is far from easy, and can result in a frustrating process that may trigger “collaborative inertia” (Bryson et al., 2015; Vangen & Huxham, 2005). Many frameworks have sought to delineate the elements necessary for multi-sector collaboration to take place; some of the common themes are described below.

Interdependence and Mutual Understanding of the Problem

Interdependence occurs when “individuals and organizations are unable to accomplish something on their own...a precondition for collaborative work” (Emerson et al., 2012, p.9). However, in order for organizations to fully embrace an interdependent approach, they need to develop an adequate understanding of the problem, its multiple layers and how multiple sectors

influence it. Thus, it is necessary for all parties to fully understand and agree on the definition of the problem, the extent to which each organization needs the others, and how invested each is in addressing the issue. Recognizing the interdependence of all partners, along with existing self-interest, are both necessary for collaboration to take place (Bryson et al., 2015).

Leaders and Sponsors

Leadership is critical to the initiation of a collaborative process to encourage others to get on board, take initiative, begin designing and structuring the process, and obtaining resources that can fund the collaborative project (Innes & Booher, 2018; Emerson et al., 2012). At least one continuous sponsor that has formal authority, and a champion with informal authority who can connect stakeholders are necessary for the success of collaborations (Bryson et al., 2015). Multi-sector collaboration is comprised of shared power in which leadership is important to ensure the achievement of goals and objectives.

Leadership, however, should also extend past sponsors and champions to include many others in order to nurture collaborative visions, processes, and structures (Bryson et al., 2015). This involves building capacity among the partners, and allowing new leaders to emerge (Innes & Booher, 2018). Leadership must also be committed to the collaborative process, respect the preferences of participants, and not demonstrate a predilection for a specific solution (Emerson et al., 2012). The type of leadership necessary for multi-sector collaboration can be described as “integrative public leadership” or “boundary-crossing leadership.” Integration in partnerships refers to the merging of differences, such as interests and perspectives, into a new whole that satisfies all parties involved and is considered a “win/win” situation (Morse, 2010).

Incentives

Incentives are necessary for stakeholders to initiate collaboration and can be internal or external. Internal incentives include problems, resource needs, interests or opportunities. External incentives, on the other hand, involve situational or institutional crises, threats, or opportunities. Incentives can also be positive. For example, a new grant or funding opportunity can drive collaborative work (Emerson et al., 2012).

A powerful incentive structure is important to ensure various actors participate and remain committed to reaching an agreement throughout the collaborative process (Innes & Booher, 2018). Incentives are essential drivers for engaging in collaborative work (Bryson et al., 2015). If the current incentive structure does not compel the necessary stakeholders to work with one another—for example, an issue is not perceived as urgent or important enough to invest time and resources—the incentive structure may be changed through legislation, lawsuits or protests to propel stakeholders to collaborate (Innes & Booher, 2018).

ACHIEVING AND SUSTAINING MULTI-SECTOR COLLABORATION: BARRIERS AND FACILITATORS

Although cross-sector collaboration is important for addressing some of society's most complex problems, cross-sector collaboration is not always successful in creating solutions, and it can even lead to negative unintended consequences or externalities. This is primarily because cross-sector collaboration seeks to address issues that arise in or occur in interconnected complex systems with feedback mechanisms; when an action is taken, the effects can be felt in multiple places (Bryson et al., 2015). Furthermore, when addressing complex problems, decision-makers need to deeply understand the interests that are being reconciled; otherwise, efforts—whether individual or collective—will not garner the desired outcomes (Gray, 1989). This involves

including stakeholders that are directly impacted by an issue, have local knowledge, and expertise in the issue to ensure the process is as well-informed as possible. The success of multi-sector collaboration requires governance that incorporates diverse stakeholders and fosters an inclusive decision-making process and accountability structure.

Good Governance

The governance of collaborations refers to the structure and processes that enable shared decision-making. Governance of collaborations usually evolves as partners develop group values, norms and trust that facilitate the coordination and monitoring of efforts. Governance is influenced by both internal and external factors. Internal factors include group size and existing trust among stakeholders, for example. Meanwhile, external factors involve preexisting relationships, as well as mandates and policies implemented by the government. The latter factors can influence power dynamics which, if unequal, can undercut collaborative efforts (Bryson et al., 2015).

Legitimacy and trust among partners and stakeholders are influenced by preexisting relationships and current networks (Bryson et al., 2006). Trust and commitment are essential for initiating collaborative work and must continue to be strengthened for the success of the collaborative project. Trust can be built through information sharing, accountability, and demonstrated competency, but ultimately relies on relationship-building (Bryson et al., 2015). “Authentic” face-to-face dialogue is also critical “to assure that [stakeholders’] claims are legitimate, accurate, comprehensible, and sincere” (Innes & Booher, 2018, p.36). Open communication is an important aspect of governance and influences collaborative work as it is the process by which shared meaning is created and modified, and drives collaborative work (Koschmann, Kuhn & Pfarrer, 2012).

Diverse Stakeholders

The emergence of innovative and adaptive policy systems that are resilient in the face of uncertainty and which can adequately address complex issues requires a diversity of participants who are dependent on one another to achieve their interests and can engage in face-to-face authentic dialogue. Diversity of participants refers to individuals who bring diverse perspectives on the issue. This does not refer to individuals considered to be influential or decision-makers alone, but rather includes individuals who have information that can enable a complete understanding of the problem and who will be impacted by the outcomes; this is necessary for the process to be fully informed and fair (Innes & Booher, 2018).

Both internal and external legitimacy are important for collaborative efforts. Externally, it is critical that a collaborative effort be perceived as legitimate (Bryson et al., 2015). This relies on identifying stakeholders that have a valid stake in the problem and recognizing previously unrecognized stakeholders (Pittz & Adler, 2016).

Internal Legitimacy

Internal legitimacy entails *procedural and structural legitimacy*, meaning that stakeholders feel included in the decision-making processes and there is a shared understanding and trust (Bryson et al., 2015). Similarly, for a collaborative process to be truly inclusive, the majority of the actors affected by a problem—including those who are not traditionally considered to be experts—are engaged in discussing the problem face-to-face. An inclusive process in cross-sector collaboration is vital for resolving differences among partners in order to develop a unifying vision and mitigate discrepancies in power (Bryson et al., 2015).

Inclusiveness requires that diverse perspectives be included in the decision-making process,

along with transparency (Pittz & Adler, 2016). All actors must be fully knowledgeable and able to freely express their views; this includes opposing views, which should be acknowledged and considered in the decision-making processes (Innes & Booher, 2018). Participatory decision-making involves more than mere information-sharing; it requires that all participants have a vote in the decisions made (Pittz & Adler, 2016). True participatory decision-making should, therefore, not be dominated by those who are more influential; everyone should have an opportunity to express their opinions to achieve collaborative rationality (Innes & Booher, 2018).

In practice, it may not be possible to include every actor. Nonetheless, an effort should be made to incorporate a representative from most affected interests. A core group can be created which can then help identify additional actors who are relevant to the issue. It is worth noting, however, that if important stakeholders refuse to participate, it can be considered unethical to proceed (Innes & Booher, 2018). Additionally, it can be difficult or unproductive to include all stakeholders in a single dialogue, and although such dialogues can be structured in many ways, one approach is to create smaller diverse working groups that report to one another and to the larger group. However, all stakeholders should be engaged in dialogue to establish process norms and establish legitimacy throughout the process and outcomes; such norms can include ground rules for dialogue and decision-making, organizational design and procedures (Innes & Booher, 2018).

Furthermore, consensus among participants should be sought. Reaching absolute consensus may not be possible, but if an agreement is reached by a large majority and an effort is made to ensure all participants are satisfied with the outcome, the process can be considered to be collaboratively rational. Ultimately, the way in which the collaborative process takes place is

very important, and involves much more than just getting a group of people to work together and partake in a negotiating process (Innes & Booher, 2018).

Accountability

Collaborations often rely on polycentric governance, in which multiple actors share authority. This can create accountability challenges, because determining what or who the collaborative is accountable to and for can be ambiguous (Koliba, Mills & Zia, 2011; Bryson et al., 2015). Typical accountability issues are heightened in collaborative networks due to the contribution of “many hands,” and because networks are typically comprised of both formal and informal relationships. Stakeholders must be able to manage both types of accountability relationships, those in which they are accountable to various stakeholders in a collaborative process, in addition to their institutional responsibilities. Informal accountability is typically a result of, “...unofficial expectations and discretionary behaviors that take shape through repeated interactions among network members cognizant of their interdependence in pursuit of their shared goal(s)” (Romzek, LeRoux, Johnston, Kempf & Piatak, 2014, p.816). When collaboration is effective, informal norms and stakeholder dynamics can lead to informal incentives, or relationships that are reciprocal and mutually accountable (Romzek et al., 2014).

Typically, cross-sector collaborations are more effective if they develop a system of accountability that allows them to document inputs, processes, and outcomes (Bryson et al., 2006). This can take the shape of negotiation and agreement documents to record decisions and provide clarity and accountability to ensure all ideas are incorporated. As new visions emerge, it is important that such documents also evolve, and help establish that the collaborative process will be ongoing, “a journey rather than a destination,” that will need to be revised and adapted as unexpected obstacles arise (Innes, & Booher, 2018, p.89).

Adaptiveness and Ambidexterity

Successful collaborative processes must adapt to new information and conditions, particularly because “the environments in which such dialogues take place are complex adaptive systems with diverse agents interacting among themselves, getting feedback from the natural and social environments, and adapting their behavior as they go along” (Innes & Booher, 2018, p.90). These conditions necessitate that collaborations operate with flexibility and the ability to adapt to change (Innes & Booher, 2018). Resiliency, continuous learning, and adaptation are strong determinants of effective collaboration (Bryson et al., 2015).

Ambidexterity refers to the effective management of conflict: “...stability versus change, hierarchy versus lateral relations, the existing power structure versus voluntary and involuntary power sharing, formal networks versus informal networks, and existing forums versus new forums” (Bryson et al., 2015, p.653-54). This process can involve using time and space to create separation to mitigate conflict, and can be very important to the success of collaborations. Ambidexterity is described as involving the “strategy of spatial separation”. In one example, it can mean maintaining stability in an organization, while modifying conditions for those engaging in collaboration. Ambidexterity also involves the “strategy of temporal separation,” which can consist of establishing decentralized relationships, networks, and power structures during the planning and strategy phases of collaboration, while relying on hierarchy and formal networks during the implementation phase (Bryson et al., 2015, p.654).

Conflict, though typically more prevalent in the early stages of a collaboration, can arise due to a myriad of stakeholder differences, such as divergent opinions on problem definition or scope, strategies for achieving the end goal, views of what the goal should be, a desire to protect or obtain greater power over outcomes and/or work deriving from collaboration by various

stakeholders, and competition over scarce resources (Bryson et al., 2015; Romzek et al., 2014). Additionally, diverse stakeholders have different organizational cultures which can be incompatible. Potential tensions coupled with the fact that collaboration efforts are also uncertain and maintaining networks is costly and time-consuming, makes collaboration work challenging (Romzek et al., 2014). Thus, flexibility in assessing options, conflict resolution skills, and addressing power imbalances are useful in managing developing tensions.

Power imbalances can pose substantial barriers to a collaboration's success; they can lead to differing expectations of the goals of the partnership and how the collaborative process will emerge. Power imbalances can also lead to differing views of who is considered an "expert" deserving of a seat at the table and can share opposing views. It is important to acknowledge power and resource asymmetries among participants as this allows for adjustments to the collaborative process, the participants, and approaches implemented (Gray & Purdy, 2014; Bryson et al., 2015). Power imbalances, for example, can be addressed by providing more opportunities for participation in discussions to partners who may have less power (Bryson et al., 2015).

IDEAL CONDITIONS FOR MULTI-SECTOR COLLABORATION

Collaboration should lead to the creation of a public good that would not have been achieved by independent sectors acting alone but can be achieved by taking advantage of strengths within each sector and reducing their weaknesses (Bryson et al., 2015). Furthermore, interdependence or a significant and mutual dependence on one another by all stakeholders ensures that every stakeholder has something that the others want or need, and is essential for collaboration to be desirable. Interdependence of interests among participants is also necessary to ensure sustained interest and commitment throughout the process, as well as motivation to reach

an agreement (Innes & Booher, 2018). This is important as progress gained by the collaboration can often rely on trade-offs by some sectors that may not be visible to other sectors (Gray, 1989). Meanwhile, effective collaborative processes have the potential to help individuals understand that their own interest can be met by working and helping others achieve their interests, thus leading to the conceptualization of the interests of others as their own due to their interconnectivity (Innes & Booher, 2018).

It is important to highlight that cross-sector collaboration, in particular, is likely to emerge in turbulent environments, as this type of collaboration is influenced by driving or constraining forces within competitive and institutional environments. Additionally, “sector failure,” or the inability for a single sector to address a problem, provides an incentive to work across sectors, and clarifies the value of a collaborative approach. This means that, in many cases, sectors engage in multi-sector collaboration primarily after attempting and failing to address a social problem on their own. The collaborative attempt to rectify that failure relies on the diversity of strengths found in other sectors in order to achieve public value (Bryson et al., 2006).

Varying theoretical frameworks have sought to better conceptualize how cross-sector collaboration can be most effective. Although there are differences between existing frameworks, these frameworks commonly emphasize the need to understand collaboration as a system that is ever-changing. The involved sectors are dynamic and interact with additional disciplines that are similarly dynamic, leading to a system that is constantly evolving. This also encourages participants to use a “design approach,” keeping the ultimate goal in mind, and then designing the processes and structures that will enable its achievement (Bryson et al., 2006).

LITERATURE ON MULTI-SECTOR COLLABORATION TO IMPROVE HEALTH

There is a growing recognition that no person or organization can single-handedly improve health outcomes and address health inequities. Many health challenges, particularly those affecting health equity are influenced by socioeconomic and environmental factors, often outside of the immediate health system (Lasker, Weiss, & Miller, 2001). For example, diabetes and obesity are influenced by the prevalence of safe spaces to exercise, and access to healthy foods. Successful collaboration is thus necessary to address complex population health challenges, particularly with sectors that indirectly influence health outcomes (Towe et al., 2016).

The United States' healthcare system includes a diverse set of professionals, organizations, services, strategies, and programs that have operated independently and have not truly functioned as a cohesive system. Meanwhile, community groups and organizations outside of the health system who indirectly influence the health of populations are often disconnected from one another. This creates yet another challenge in complementing or reinforcing each other's work, and developing strategies that can achieve a meaningful health impact (Lasker et al., 2001). Importantly, social determinants of health, which have a significant influence on health outcomes, typically do not fall within the formal authority of public health agencies, a fact that may require "...reassign[ing] responsibility and power within the system" (Zahner, Oliver & Siemering, 2014, p.1). Given that health is inherently an interdisciplinary field, collaboration is critical for achieving better health outcomes (Zahner et al., 2014).

Collaboration and partnerships are necessary to create community-based solutions capable of advancing health equity by improving a community's ability to shape outcomes and promote multi-sector collaboration. This requires involvement of traditional health-oriented

organizations as well as other public and private sectors, such as businesses, faith-based organizations, education, housing, transportation, planning and land use sectors, among others. Multi-sector collaboration can lead to "...disruption, innovation, paradigm shift, and design thinking..." which are some of the guiding principles for engaging in such work (NASEM, 2017, p.383).

Multi-sector collaboration in health, however, is an emerging field as systems have traditionally operated in silos in order to maximize efficiency, concentrate expertise, and improve logistics. But if improved outcomes are to be achieved, it is necessary to find novel ways of defining issues and engaging in cross-sector collaboration (NASEM, 2017). Partnerships in the field of public health seek to improve conditions that will lead to improvements in the health and well-being of entire communities. These partnerships typically employ strategies from multiple fields such as community organizing, community development, and policy and advocacy, among many others. Similarly, multi-sector collaboration in public health can take the shape of coalitions, alliances among service agencies and health care providers, as well as larger grassroots or advocacy initiatives. Meanwhile, the goals of partnerships in public health can involve a variety of specific outcomes and issues, complex interrelated concerns, and/or social determinants of health. Despite this, multi-sector collaboration in health continues to be limited (Roussos & Fawcett, 2000).

The lack of existing collaboration is not due to a lack of awareness of its potential benefits, but rather that, in practice, collaboration and its outcomes are difficult to achieve successfully. Collaborative work can be a frustrating process that is time-consuming and resource-intensive. Additionally, collaboration requires relationships, processes and structures that differ from how organizations typically operate. Yet, collaboration, if successful, can be

meaningful in its ability to create linkages across sectors and organizations that are currently not working towards a common goal (Lasker et al., 2001).

In health literature, collaboration has been defined as “a process through which parties who see different aspects of a problem can explore constructively their differences and search for solutions that go beyond their own limited vision of what is possible” (Lasker et al., 2001, p.165). Organizations from different sectors are familiar with different lines of work that can complement one another and create a larger impact. This is particularly true when organizations that do not work in traditional health-related fields are engaged, in order to contribute a unique perspective as well as additional resources and skills to improve environmental, social and economic factors. Organizations are also beginning to consider data focused on social factors, such as employment and housing, as indicators for health, supplementing other health-related data and statistics to assess health and well-being (Lasker et al., 2001).

ESSENTIAL MULTI-SECTOR COLLABORATION ELEMENTS TO PROMOTE HEALTH AND HEALTH EQUITY

Many of the aspects of multi-sector collaboration apply to some of the frameworks used to advance health and health equity, while other frameworks were created specifically for health or borrowed from other fields but used to inform multi-sector collaboration processes within these fields. Cross-sector collaboration to improve well-being focuses on maximizing opportunities for cross-sector collaboration particularly with “partner” sectors in health, as well as in organizations or sectors beyond healthcare and public health, including housing and community development. In order to ensure successful collaboration, each sector should be meaningfully engaged and should benefit from its active participation in a partnership (Towe et al., 2016).

Evidence from community health promotion trials have provided insights into some of the key levers necessary for successful collaboration, which include a clear vision and mission, appropriate levels of financial investment, and monitoring progress in order to continuously modify processes in order to achieve goals. Additionally, it is important to engage partners as leaders in order to effectively distribute power and have active participation in decision-making processes (Towe et al., 2016).

The collective impact model has also informed public health efforts. Collective impact is an approach for “creating large-scale social change” by addressing complex issues through the alignment of government, nonprofit, philanthropic and private sectors. The premise underlying the collective impact model’s approach is that it is intended to tackle an issue from multiple sectors and perspectives, by coordinating efforts and drawing lessons learned. Organizations typically operate via “isolated impact,” meaning that a prominent organization is funded to implement an innovative idea that if successful can be replicated across other organizations. However, there is little evidence to support the success of such approach, moreover, no single organization is responsible for major social problems. However, moving from isolated impact to collective impact entails more than mere collaboration, but rather a “systemic approach to social impact” guided by inter-organizational relationships and a commitment to work towards shared objectives (Kania & Kramer, 2011). Collective impact emphasizes the creation of public-private partnerships, and requires the following conditions to achieve success: a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and a backbone organization (Flood et al., 2015; Kania & Kramer, 2011). Although previous frameworks have included the need for dedicated staff to sustain collaborative work, the collective impact approach takes that a step further, claiming the need for an organization with the necessary skills

and resources to coordinate the necessary elements to achieve collective impact (Pittz & Adler, 2016; Kania & Kramer, 2011).

Health literature also highlights additional drivers and/or places significant emphasis on certain elements of multi-sector collaboration that are important to advance health and healthy equity, as explained below.

Table 2: Features of Multi-Sector Collaboration to Promote Health and Health Equity

Features	Summary Description
Adequate Funding	Adequate funding is important to sustain collaborative work over long periods of time.
Supportive Policies	Policies at the federal, state, and local levels that support collaboration are critical to the success of multi-sector collaboration for health equity.
Messaging and Health Literacy	Diverse sectors must understand how their work is linked to health outcomes in order see value in engaging in collaborative work.
Vision to Promote Equity	Multi-sector partnerships that seek to advance health equity should also be committed to promoting equity in all processes and outcomes.

Adequate Funding

The need for funding for multi-sector collaboration to advance health has gained significant prominence, and foundations such as the Robert Wood Johnson Foundation, which is leading cutting-edge work around health equity, have included multi-sector collaboration as part of their Culture of Health Action Framework. Evidence demonstrates that partnerships must find diverse funding sources, particularly as collaborative work will take place over long periods of time in order to effectively tackle complex challenges, something that is particularly true in the field of public health. However, financial support must align with nonfinancial investment, such as leadership commitment and stakeholder buy-in. And funding at a level that is more than just

tolerable is needed for collaboration to be successful (Towe et al., 2016). Similarly, the preconditions to effectively apply the collective impact model include, "...adequate financial resources, an 'influential champion' to engage decision makers and stakeholders across sectors, a 'sense of urgency' for change, and an understanding that current approaches are insufficient" (Flood et al., 2015, p.656). Resources alone will not ensure the success of a collaborative effort. However, having an adequate and sustainable level of resources is critical. Additionally, it is imperative that funding supports the collaborative's mission and vision and that it is flexible to ensure long-term success (Woulfe, Oliver, Siemering & Zahner, 2010).

The community development sector has also become a natural ally for the field of public health and is one from which the field of public health can learn about diversifying funding streams. Community development typically involves collaboration by nonprofit service providers, real estate developers, financial institutions, foundations, and government to improve neighborhoods, and reduce poverty, all while catering to diverse communities and improving health equity. For instance, some housing projects are designed for grandparents raising grandchildren, while others serve migrant farm workers, or individuals with HIV. Given the work that the community development sector has done to address some of the upstream causes of poor health—such as housing insecurity, poverty, and education—partnerships with the health system can lead to additional significant benefits to further improve opportunities for health in low-income communities. Furthermore, community development has been successful at blending funding streams from federal and local sources, including government subsidies, foundation grants, bank loans and investment, equity investments, and tax credits to address the needs of community members (Erickson & Andrews, 2011).

Supportive Policies

Another important driver of cross-sector collaboration for health and health equity are policies at the federal, state, and local levels that support collaboration. One such example is Health in All Policies (HiAP), a model that incorporates health in the decision-making processes of all sectors. The HiAP model focuses on long-term health considerations over short-term impact and cost, thus shaping solutions and structures using a “social-determinants-of-health approach” that has promoted collaboration across sectors within government (Towe et al., 2016). The goal of HiAP is to engage diverse government stakeholders to collaborate in promoting health, equity, and sustainability while also advancing the goals of other government agencies, such as via job creation, increased transportation access, and educational attainment, among others (NASEM, 2017). The HiAP approach grew out of the recognition that health is impacted by factors outside of the scope of the health sector, and entails assessing the effects of government policies on health and the social determinants of health, so that these are considered in decision-making processes (Ollila, 2011). The key elements of HiAP are similar to those included in other cross-sector collaboration efforts, such as, achieving “co-benefits,” engaging stakeholders, and creating structural and process changes. However, HiAP also seeks to use a health equity lens to achieve its goals, and ultimately prevent negative health externalities, that would not have come to light if health impacts had not been considered in policymaking (NASEM, 2017).

HiAP approaches can be established at both the state and community levels. California has created a Health in All Policies Task Force across 19 state agencies, departments and offices, with the intent of developing interagency partnerships to tackle issues related to health, equity, and environmental sustainability. Seattle-King County, Nashville, and Atlanta have also

developed public-private multi-sector partnerships to improve social justice, equity, and overall well-being of their respective communities (NASEM, 2017).

Messaging and Health Literacy

Developing effective messaging and supporting health literacy are also fundamental for ensuring that a process like HiAP is successful. Health literacy or a good understanding of the different factors that influence health by the general public, decision-makers, and the media is critical to adequately understand the potential impacts of policies on health outcomes (Ollila, 2011). Furthermore, it is necessary for diverse sectors to understand how their work is linked to health outcomes in order see value in engaging in collaborative work. It is important for partners that are engaging in collaborative work, "...to reframe how all partners talk about health, well-being, and health equity using a co-learning strategy," to achieve success in cross-sector collaboration. Co-learning from one another not only helps create win/win opportunities but also helps stakeholders identify new opportunities (Nweke, 2017, p.99).

Vision to Promote Equity

The primary goal of HiAP is to address social determinants of health that influence health inequities. HiAP can be applied to specific collaborative efforts or can be used to modify government structures and processes to influence health outcomes (Wyss, Dolan, & Goff, n.d.). Similarly, multi-sector partnerships that seek to advance health equity must engage around issues that promote health, equity and sustainability, as is the case of the HiAP approach. However, the process of engaging in multi-sector partnerships can also help advance equity. For instance, cross-sector collaboration can also promote equity via leadership models that distribute power

and decision-making, by incorporating organizations that can address or bring to light health perspectives from groups that have been historically underrepresented (Towe et al., 2016).

SUSTAINABILITY OF MULTI-SECTOR COLLABORATION TO IMPROVE HEALTH AND HEALTH EQUITY

Diverse funding streams and supportive policies are not only important drivers of multi-sector collaboration but are also important for the sustainability of such efforts. Other aspects that are critical include human capital development, such as skill-building or staff development, including a diverse set of stakeholders who represent important segments of the population, and organizational capacity and supportive structures that allow for communication, efficiency and effectiveness (Hearld, Bleser, Alexander & Wolf, 2016).

Furthermore, tapping into community assets, and utilizing an assets-based approach focused on positive resources that communities have to offer, rather than a deficit approach, focused on what communities lack, is critical. Community capacity can also be reinforced to ensure long-term impact by building on a community's resources. This can be achieved through "...data, leadership training, advocacy training, and education about issues that affect them" (Nweke, 2017, p.100). Such efforts will lead to greater sustainability of efforts while strengthening a community's capacity to address problems.

There are evidently many different perspectives on the necessary levers that enable the success of multi-sector collaboration. Although there are similarities across frameworks, different elements were emphasized for the success of collaborative efforts to improve health and/or achieve health equity. Nonetheless, multi-sector collaboration in health is a field that is still growing. A "Pulse Check" conducted by ReThink Health in 2016 found that although many partnerships have existed for decades, the number of multi-sector partnerships in health have

grown since 2010 (Erickson, 2018; Siegel, Erickson, Milstein & Pritchard, 2018). Despite the fact that evidence shows that multisector partnerships have led to improved short- and long-term effects in population health for regional health systems, achieving mature stages of development in multi-sector collaboration is challenging; so much so that even organizations with a reputation for being in mature stages of development lacked some of the necessary elements that would make them “poised for transformation” or that would enable them to achieve success (Siegel et al., 2018). Although the reasons for this varied, some common themes included a lack of adequate funding, inadequate infrastructure to foster collaboration, a focus on short-term initiatives primarily focused on a specific health outcome or condition, a lack of connection with other important community efforts, or the absence of important players (Erickson, 2018; Siegel et al., 2018). Evidently, despite existing frameworks and literature on the value of multi-sector collaboration, in practice it is difficult to achieve. There is still much to learn with regards to multi-sector collaboration within the health sector, as well as to advance health equity.

CREATING OPPORTUNITIES TO ADVANCE HEALTH EQUITY THROUGH MULTI-SECTOR COLLABORATION IN PRACTICE

For my doctoral thesis, I worked with three organizations on three different types of projects that provided me with distinct lenses for understanding and using multi-sector collaboration to advance health equity.

For my first project, I worked with a Department of Health conducting qualitative research on perspectives on health equity among community stakeholders. This research elucidated some the challenges community-based organizations face when trying to do work outside of their immediate sector, as well as the complexity of creating functional relationships with local government.

My second project was with the California Primary Care Association (CPCA), where I conducted a survey and qualitative research to inform the strategic plan of their National Health Center Immigrant Workgroup, comprised of health care organizations throughout the country. This work centered around coalition building for protecting access to health care for immigrant patients, and brought to the forefront the benefits and challenges of working within a coalition on a topic that is currently highly politicized.

Finally, I worked with the National Collaborative for Health Equity and created policy briefs on various factors that influence health opportunities. This project highlighted some of the strategies used to make health equity relevant to different stakeholders, taking into consideration the messaging and language used to describe issues in order to make them more accessible to stakeholders from diverse sectors.

In the next section I discuss each project in more detail, and in the final section I draw lessons learned about intersectoral collaboration.

DEPARTMENT OF HEALTH

As part of my doctoral thesis work, I collaborated with a Department of Health (DOH) to better understand views, priorities, and perceptions of health equity and multi-sector collaboration among stakeholders from diverse sectors. The DOH was interested in developing this work to inform future health equity collaborative efforts.

Goals of Project

Specifically, the goals of this work were to determine the views of individuals working in different sectors (e.g., housing, food access, behavioral health, health care, etc.) on five issues:

- participating stakeholders' definition of health equity;

- barriers to health;
- health issues that were most important to participants;
- significant challenges to working across sectors; and
- recommendations for improving intersectoral collaboration.

The findings were presented as a report, highlighting significant themes and quotes from the interviews. The primary audience for this report was the Department of Health. The report allowed the DOH to develop a deeper understanding of current perceptions on health equity, and the likelihood that stakeholders would be willing to collaborate to address some of the social and structural issues currently affecting diverse communities throughout the city.

Methodology

Sixteen semi-structured recorded interviews, 30-45 minutes in length, were conducted among leaders of community-based organizations and coalitions. The interview guide was developed in collaboration with the DOH to assess stakeholder understanding of current health issues affecting the city, perceptions and experiences in working with local government, as well as their likelihood to engage in multi-sector collaboration to address the health inequities affecting their communities and the city at large.

Research participants included nine direct health care service providers of which six were Federally Qualified Health Centers (FQHCs), and two were providers of behavioral health services. Other participants included local community-based organizations focusing on a range of issues, such as housing and food security, as well as associations and coalitions. Purposive sampling was used to identify interview participants in an effort to get a representative sample of organizations throughout the city. All interviews were recorded and transcribed using an interview identification number to protect the anonymity of interview participants. A codebook

was then created using codes and domains inferred from the interview guide, which evolved as the interview process and analysis began and additional codes and domains arose. Once the coding process had taken place, themes were identified and a thematic network analysis was conducted. For the purposes of the qualitative analysis, Nvivo software was used.

Findings

Although much can be learned from the interviews, for the purpose of this doctoral thesis, the focus will be on the following key areas:

- stakeholders' definition of health equity;
- significant challenges to working across sectors; and
- recommendations for improving intersectoral collaboration.

These three areas are of most relevance for this thesis and elucidate some of the challenges and opportunities for intersectoral collaboration to address health inequities.

Health Equity

When participants were asked what health equity meant to them, most defined health equity as:

- improving access to health via social drivers such as access to education, housing, food and other resources, including health care; or
- increasing access to health care alone.

Multiple social drivers of health. Most interviewees defined health equity as working towards addressing multiple social determinants of health, in addition to health care. For instance:

...I think it's [the] opportunity to live, and work, and be productive, without having your life shortened...if you live and work in a condition that doesn't damage your health, and lets you be active and productive and live as long as you can, this is health equity.

To this participant, health equity meant having the opportunity to live and work in an environment that does not reduce opportunities to be healthy. Another interviewee articulated that health equity can be defined as:

...all people have access and ability to have all the tools to be healthy...everyone has access to affordable housing, everyone has access to you know, grocery stores with fresh food, and that people have access to clean air and clean water.

This participant articulated health equity as equal access to the tools necessary to have a healthy life. Another interviewee explained that health equity means that a person's social characteristics, including the place in which they live, are not an indicator of their health:

...when people have health equity you wouldn't be able to predict them to have poor health outcomes based on either their race, or their color, or their social economic background that's when you have health inequity when you can predict that a group of people will have poor outcomes based on you know, sort of identifiers like their race or their ethnicity, or even the part of the city they live in.

This interviewee alluded to the fact that people of color and people from low socioeconomic backgrounds suffer most from health inequities and that if health equity was achieved, these characteristics would not be a determinants of poor health outcomes.

Equitable or broader access to health care. Nonetheless, a significant number of interviewees described health equity as involving equitable or broader access to health care

alone. For example, “...it’s giving the person with insurance and the person without insurance the same health care...health care for everyone, single-payer”. This interview defined health equity as being single-payer system, highlighting the prevalent view of health and health equity as only involving health care. Another interviewee added, “to me, health equity means that everyone, regardless of who they are or where they live, or how much money they make, should have access to quality health care, no matter what”. Although health care is an important aspect of health equity, it is only one of many drivers of health outcomes, and thus a much broader view is necessary. Another participant described their experience of having to explain why the health center in which they work is interested in determinants of health beyond health care:

Yeah, we have to push...if I talk to lawyers to discuss immigration policy...they don’t understand why a health center is concerned with immigration, right? They think immigration is something that concerns lawyers or social service organizations...it’s not really intuitive...people don’t think about health.

This participant illustrates a knowledge gap in what health or health equity means to individuals working in non-health sectors, and how addressing that gap can be an important steppingstone in allowing diverse sectors to understand how their work influences health outcomes.

Challenges for intersectoral collaboration

When participants were asked about what made intersectoral collaboration challenging, many highlighted different organizational structures that promote siloed work and make collaborative work challenging. Some of the most prominent responses as to why engaging in intersectoral work is challenging were:

- a lack of adequate funding to engage in efforts beyond their immediate line of work;

- silos within sectors as well as differences in priorities, that make reaching a consensus and setting priorities difficult;
- a lack of time or capacity to engage in such work;
- a need for better data and information-sharing, particularly across systems of care/service; and
- inadequate involvement of communities or individuals directly affected by issues that are being addressed.

Silos within sectors and a lack of adequate funding. The following quotes illustrate how silos within sectors and a lack of adequate funding, or the ways in which funding and resources are currently allocated make collaborative work challenging. For example:

... barriers are sort of ownership and not getting out of your silo. Barriers may be in terms of how the payment moves, right? You might get paid for A, you don't get paid for B, but we know that B is really important.

Although silos within sectors are a barrier, the current payment structures tend to feed into siloed work as organizations are often not compensated for addressing issues out of their direct scope of work.

Limited time and resources. Another interviewee further articulated the relationship between funding structures and silos, highlighting that organizations operate under limited time and resources:

I mean, I assume it's just a financial tendency to silo and to focus on the issues the organization works [on], and to focus specifically on the kind of issues that you do, and the fact that the kind of collaboration that you're referring to takes a pretty substantial

investment of time and probably resources as well, and most organizations don't have that or don't see it as their top priority. They're already for the most part stretched in terms of resources...I guess it's largely an issue of whether organizations have the staff, capacity and staff time and just resources to do it.

According to this interview, a lack of resources, including capacity and staff time were significant barriers in engaging in collaborative work. Another stakeholder explained that:

Time is, you know, limited for all of us and we pick and choose where we invest our time, and so I think that trying not to duplicate conversations, but to enrich conversations that are already happening can really be helpful in kind of reducing the barriers to moving forward.

Although time is limited, this stakeholder suggested that engaging in current efforts or conversations already taking place was a way of infusing collaborative elements without investing more time.

Different priorities. Another stakeholder added that it is difficult to achieve consensus particularly among people with different priorities:

I have a very personal experience that collaboration is really hard, especially among different stakeholders. It's really hard to get people on the same page. It's difficult to get people to come to a consensus and agree. I think when people have different priorities and different focus areas then collaboration is difficult...

Although collaboration is necessary to address intractable problems, successfully achieving a collaborative process is also very difficult.

Data integration and sharing. The need for integration of data and data sharing was also a prominent issue among interviewees. One stakeholder expressed the issues as follows:

You know, the lack of integration of data and systems...we have pretty good integration of the healthcare sector, but when we begin to look at behavioral health, or we're beginning to look at social sector data...those databases and that information is not necessarily shared so that we can really get a good picture of what the factors are for impacting an individual's health status...And the constituency and the consumers should have to be at the table too.

This participant highlighted the need for comprehensive data integration and access in order to look at issues more holistically.

Community involvement. Another interviewee indicated that a lack of collaboration with people who are directly affected by issues is another important gap:

...I think the hardest collaboration is really between organizations and government, with people who are directly impacted by problems...I think that is one of the kinds of engagement that I think is most lacking and figuring out how to follow the leadership of communities and help and making sure that they can solve their own problems, you know, it's not just looking for outside solutions. But how do we work with residents...to create more opportunities to work in a healthcare field that would actually benefit communities? And how do we think creatively with communities about solving...what seems like intractable problems?... And I think that is the real challenge...there's I think, sometimes a lack of creativity to do things differently than we've always done them.

This stakeholder highlighted the need for organizations and government to collaborate with local communities and to allow individuals to be active participants in creating solutions to the issues affecting their communities.

Participants highlighted that working across sectors is very challenging. Stakeholders typically understood the value of this work but described the lack of appropriate funding, time and capacity to engage in this work. Organizations tend to be stretched thin, and when prioritizing where to invest time and resources, it is often easier to focus on their siloed line of work. Additionally, as one interviewee described, reaching consensus among many different stakeholders is difficult, particularly when organizations have different priorities and focus areas. Not only is it challenging to bring diverse stakeholders together due to a lack of capacity and financial resources, but it is also difficult in terms of process to move forward, commit and reach consensus and agreement once such collaboration has been initiated.

Opportunities for intersectoral collaboration

Interviewees were asked about their recommendations for enabling, strengthening, and encouraging intersectoral collaboration, as well as current challenges for achieving collaboration across sectors. When participants were asked about their recommendations for intersectoral collaboration, participants highlighted the need for:

- training on what health equity is and what equitable institutions would look like;
 - training on the importance of collaborative work for addressing health inequities. This includes using the collective impact model and appropriate messaging to have stakeholders from different sectors understand how their work influences health;
 - inter-governmental collaboration, to model collaborative work for other organizations;
- and
- funding of work that requires intersectoral collaboration by foundations or local government.

Education on the meaning of health equity. The need for greater education and/or training on what health equity means was highlighted by several participants. For instance:

...people who are trained in public health know that other things impact health, but I'm not sure people who are trained in say urban planning or transportation understand that their work is health...getting the message out to those other disciplines that they are also contributing to good health, and...[are] public health practitioners too....

Stakeholders also highlighted the need to educate different sectors on how their work influences health and can help achieve greater health equity. As expressed by one participant, there is a need for individuals who are not currently working on healthcare to view themselves as “public health practitioners.”

Training on equitable institutions. Another interviewee emphasized the need for training around equitable institutions, as well as further discussions around the necessary reforms that would enable change to be achieved,

I think people need to be trained in what it means to have equitable institutions. I think that's one of the first barriers that [there] is not a good understanding of what it would take and what it means. So I think on one hand you can probably get virtually everybody in the city to say, 'yes, there's disparities that exist in income, and health care, and in housing....,' but I think that first we don't know what it would take...I think that would mean probably reform in the tax system, so that there [is] really more revenue to address the issues. I think in the long term it would pay off in terms of the quality of life and even in the cost of public services...but in the short term, you have to find those resources and have the commitment to that.

According to this stakeholder, there is currently a knowledge gap in terms of the type of work required to achieve equitable institutions and the structural changes and collective sacrifices that will also need to be made in the short-term to see positive outcomes in the future.

Collective impact. Educating stakeholders on the importance of using effective frameworks to structure collaboration to address health inequities was also recommended. In the words of one participant:

...I think that the community at large probably needs some education about what exactly health equity is and how it can be addressed collectively, I know that a number of my member organizations appreciate the collective impact model for bringing together diverse stakeholders and trying to address wicked problems...I think probably providing some sort of structure to have those conversations is also valuable and I think that, some of that too is probably about finding places that people are already naturally gathering [in] and trying to kind of infuse a health equity framework into those conversations instead of necessarily recreating everything from scratch...

This stakeholder discusses the value frameworks such as the collective impact framework can have in terms of helping everyone understand their role towards achieving health equity.

Messaging. Another participant mentioned messaging as an important element to enable collaboration:

...I think the messaging is important, understanding that we're all in this together. We move the needle because we understand all of the interrelationship between all of the service providers and the organizations...So I think it's awareness, understanding of the interconnectedness, I think it's convening, and I think it's really all of us understanding that...we can't move the needle alone, we have to do it collectively. So, using the collective

impact model is really important, and sharing both in vision and in goals, to achieve [collaboration], and being clear about what the roles are that we each play, right? There isn't any one player that can do this, we have to do it collectively.

Participants mentioned the need to use the collective impact framework to help stakeholders understand their role in health and the changes that are necessary to reduce health inequities.

Collaboration within local government. The need for greater collaboration within local government was also a key theme that emerged, and is exemplified by a participant below,

...I think that if you could model collaboration...that would be the easiest thing to bring [local government] together. Well maybe not the easiest, but the most obvious thing, and then I think you would say, hey, why are we only thinking about very traditional health and traditional terms and your physical and mental health, but why aren't we thinking about the whole person in terms of their environment, which means that we really need to be collaborating and working with housing and you know education...All of those pieces need to be flowing together and not just working really hard within our own lane here...People are very protective about their own resources and their own responsibilities...[they] forget to stop and say, this isn't really about me and my job and my department, but it's really about this city and the health of the city.

This interviewee described the general silos and divisions that exist within local government, which is often the way many government departments operate, and suggested the need for a more integrated system focused on whole health. Many other participants also discussed the importance of bridging the various government departments, in terms of data, funding streams and lines of work.

Funding multi-sector collaboration. Another stakeholder suggested providing funding for multi-sector collaboration to incentivize this work:

...you don't know what you don't know. You don't know who's working on various issues. And who you should be reaching out to...and it doesn't appear that there is sort of a governing body, who is taking that on and who is doing that, so hard to know who to reach out...I just think it'd be great if the DOH and the city set aside some money for intersectionality work... I forgot who the funding body was...and they ultimately focused on homelessness, you know, sort of a chronic disease management for homeless populations and ...they focused on addressing those health outcomes...and so I think if the city or the DOH would...engage in projects of that nature, that sort of stimulated organizations, and maybe even incentivized them to work together on various problems, or subpopulations...

This participant articulated the need for grants and funding sources to require or incentivize organizations to work with one another as a means of increasing opportunities for collaboration. Different organizations have different funding streams that often do not enable or promote intersectoral collaboration. Providing funding to a leading organization to do intersectoral work and collectively address a specific issue(s) could be one avenue of addressing this gap.

Recommendations and Next Steps for the Department of Health

Based on these findings, and considering that the city in which these interviews were conducted has its own set of political dynamics, collaborative initiatives, and health inequities, the following recommendations were offered to the Department of Health:

- Educate local stakeholders on health equity and use frameworks, such as collective impact, to help diverse stakeholders understand their role within the context of addressing

health inequities. Many interviewees discussed a lack of general understanding of what health equity is and what diverse stakeholders can contribute to health equity, especially those in non-traditional health sectors. Interviewees explained that individuals trained in public health understand the impact that organizations working in housing, education and transportation, to name a few, have on health, but that is less common among individuals working in other sectors. Thus, more education on health equity using frameworks, such as collective impact, will help everyone better understand their role in influencing health outcomes.

- Incorporate health equity principles in places in which community organizations and coalitions are already meeting to avoid recreating existing efforts. Many interviewees discussed a lack of capacity for organizations to engage in efforts beyond their scope of work. Interviewees also mentioned having to be selective of the meetings and efforts they engage in, due to insufficient time and resources. Therefore, promoting health equity efforts and providing education on health equity can be done within established meetings or in places where organizations are already engaging to avoid replication of efforts.
- Government and foundations should fund multi-sectoral work. Interviewees expressed that it is challenging to engage in multi-sectoral work due to a lack of adequate resources. This leads to silos of work because it is more cost-efficient in the short run for individual organizations to focus on their own issues and work. One interviewee explained that a few years ago, a grant was provided by a funder to a core group of providers to tackle homelessness collaboratively based on the expertise of all actors; this funding incentivized organizations to work with one another. Consequently, providing funding for

multi-sector collaborative work is one way of ensuring that multi-sector collaboration is a priority among different organizations and stakeholders.

- Integrate data across sectors. Interviewees discussed the need to see the whole picture for better outcomes, which requires data sharing from different government departments, including healthcare, behavioral health, education, human services and employment services. Data sharing can bridge some of the knowledge gaps that currently exist and help agencies focus on whole person health. A shared measurement system is also in alignment with the core principles of the collective impact model (Kania & Kramer, 2011).
- Involve communities in identifying solutions to their problems. Communities should be involved in addressing the issues that affect them and identify the best process for doing that. Stakeholders discussed that it was difficult for local government and organizations to determine how to best engage with local communities and involve them in addressing challenging issues. Engaging with local community members early in the process and allowing space for feedback and participation can help reduce some of the tensions that may currently exist.

CALIFORNIA PRIMARY CARE ASSOCIATION

My second doctoral thesis project was based at the California Primary Care Association (CPCA) during the fall of 2018, working on a project with the National Health Center Immigrant Workgroup. Unlike my work with the Department of Health, the focus of this project was not health equity specifically, but rather on health care access of immigrant communities. Nonetheless, this project provided important insights into multi-sector collaboration for

advancing health equity because increasing access to health care for immigrant communities is important to advance health equity in the state of California and nationwide.

CPCA represents the interests of more than 1,300 community health centers and 17 Regional Clinic Associations throughout the state of California. Its members range from free clinics, federally funded clinics and large and small clinic corporations. Community health centers (CHCs) are critical for elevating the health of low-income, uninsured and underinsured communities, not just through health service provision, but because of their expansive network of resources and information to serve the unique needs of their patient population. CHCs must collaborate with a range of partners to provide this broad range of services and resources, including educators, lawyers, housing and food access professionals, among many others. Thus, the work of CHCs offers an interesting perspective on multi-sector collaboration and some of the challenges in serving a diverse range of patients, as well as strategies for addressing health inequities among their patient population.

CPCA engages in advocacy, education, and technical assistance, all of which are designed to enhance the ability of CHCs to do critical work, and highlight the important role of CHCs in delivering health care and improving the health of their communities. Services offered by CPCA include tailored programmatic or technical assistance to improve the operational, financial, leadership, workforce, and clinical and quality capacity of its members.¹ CPCA is unique among many other primary care associations in that it has a 501(c)(4) arm, CaliforniaHealth+Advocates, that engages in direct state and federal advocacy in order to advance the mission of community health centers in the state of California. CaliforniaHealth+Advocates highlights the important

¹ Additional information is available on the CPCA website (<https://www.cPCA.org/cPCA/>).

role that primary care associations and CHCs play, in elevating and addressing the needs, and improving the social determinants of health of diverse patient populations.²

National Health Center Immigrant Workgroup

CPCA, along with the Association of Asian Pacific Community Health Organizations (AAPCHO), and the National Association of Community Health Centers (NACHC), initiated the National Health Center Immigration Workgroup (NHCIW) during the spring of 2018. The initial purpose of the NHCIW was to provide health centers and primary care associations the opportunity to address concerns at the intersection of immigration and health, and provide information and resources on policy changes that impact health centers and immigrant patients. At the time this project was conducted, more than 180 organizations from across the U.S. were members of NHCIW, including state primary care associations, health systems, individual CHCs, non-profit and advocacy organizations that serve immigrant communities, and academic institutions. Webinars, toolkits and web-based resources were some of the major means NHCIW used to engage its members. These webinars attracted from 60 to more than 400 participants at a time. Although webinars were organized in a bit of an ad hoc manner, they typically took place once a month, and covered a range of topics, largely dependent on critical policy issues at the time. Some of the webinar topics included protecting immigrants from Immigration and Customs Enforcement (ICE), Deferred Action for Childhood Arrivals (DACA), supporting undocumented individuals, resources on the public charge rule³, and the 2020 Census.

² Additional information is available on the CaliforniaHealth+Advocates website (<https://www.healthplusadvocates.org/advocates>).

³ The public charge rule consists of an inadmissibility assessment set by the Department of Homeland Security with which applications for visas and lawful permanent resident status are adjudicated. People have historically been considered a “public charge” if they rely on the US government for subsistence, and can be denied a visa or residency if they are considered likely to become a public charge based on a compilation of characteristics, such as age, income and level of education. Changes to the public charge rule took effect on February 24, 2020, which

Goals of Project

While working for CPCA, I collaborated on the strategic planning efforts for the NHICW. This included conducting a survey and series of interviews of NHICW members to help determine how the workgroup could become more collaborative and improve member engagement, in the context of the specific needs and interests of individual participating members. The specific goals of this project were to:

- gather insights on immigration-related needs among participating organizations;
- determine how to best engage member organizations, moving beyond the current unidirectional sharing of information and resources to allow members to be active participants;
- identify priorities and issues areas for the NHCIW; and
- develop a unified mission and purpose for the NHCIW.

Both the interviews and survey helped NHCIW understand more about the needs of its members, and made clear the many challenges of fostering collaboration among diverse organizations that are separated geographically, often on different ends of the country, and operating in states and environments with very different characteristics, political realities and priorities. The guiding questions of the interviews and the surveys served to gain information on:

- What challenges was each organization facing in its immigration advocacy work?
- What value, if any, was NHCIW bringing and what was most valuable to workgroup members?

redefined the meaning of “public charge” to incorporate nutrition, health care, housing benefits and cash assistance into the public charge assessment (NILC, 2020).

- How comfortable was the organization with the messaging regarding immigration policies in the advocacy materials produced by the NHCIW?
- What could NHCIW do better to help and address the diversity of needs among its members?
- How would NHCIW participants like to continue to engage with the workgroup?
- Given that the workgroup gained considerable traction after the changes to the public charge rule was proposed, what should be the mission and purpose of the NHCIW moving forward?

Methodology

For this project I conducted a series of interviews and surveys (explained in more detail below). Given that the workgroup had a membership of over 200 individuals, conducting a survey allowed me to efficiently obtain information from a large set of stakeholders, and allowed everyone the opportunity to engage in the strategic planning of the workgroup and voice their needs and priorities. The interviews were conducted among a smaller subset of individuals (n=10) and provided additional context to the data collected through the survey.

Interviews

In the first phase of this project, I interviewed a range of organizations that worked on immigrant health issues. The goal was to gather more in-depth information regarding the needs of various organizations that would not be possible to achieve through a survey alone. The questions focused on the stakeholders' motivation for joining the workgroup, what the workgroup could improve upon, and the means and vision through which various stakeholders wished to continue to engage with the workgroup.

All interviewees were identified via purposive sampling to get a representative sample from organizations based in different geographical areas of the United States. Ten interviews were conducted: seven with primary care associations or associations of community health centers (70%), two with immigrant rights or advocacy organizations (20%), and one with a community health center (10%). Although most organizations were part of the NHCIW membership, the sample also included two organizations that were not part of the NHCIW, but that engaged in immigrant rights or health advocacy, to determine how the workgroup could further extend its existing network of organizations.

Each interview was approximately 30-minutes long and conducted using a semi-structured interview format (see Appendix 1 for the interview guide). A codebook was then created using codes and domains inferred from the interview guide, which evolved as the interview process and analysis began and additional codes and domains arose. Once the coding process had taken place themes were identified and a thematic network analysis was conducted. For the purposes of the qualitative analysis, ATLAS.ti software was used.

Survey

In the second phase of the project, I designed and conducted a survey (see Appendix 2) that was extended to all NHCIW members (defined as people who had registered with NHCIW to receive resources, notifications of the webinar, etc.). The goals were to determine the types of immigration-related activities that organizations were engaging in; identify additional resources organizations needed; get feedback on whether organizations were comfortable with current messaging of materials provided; and identify aspects of the workgroup that were most helpful and those that could be improved upon.

A total of 251 individuals were invited to participate in the survey. Thirty-three NHCIW members responded to the survey (a 13% response rate) during a 15-day window. Respondents included health centers (45%), primary care associations (33%), policy and advocacy organizations (9%), primary care consortia (3%), legal aid organizations (3%), organizations that provide technical assistance to health centers (3%), and academic organizations (3%). Although 33 responses were not a large enough sample to be fully representative of the entire NHCIW population, the response rate was greater than anticipated, given lower response rates for prior survey requests from NHCIW membership.

Findings

Some of the major findings from the interviews and surveys were consolidated in a report (see Appendix 3) and are outlined below:

- challenges of engaging in immigration advocacy work;
- positive aspects of the NHCIW;
- recommendations for the mission and purpose of the NHCIW; and
- areas of improvement for the NHCIW.

These findings elucidate some of the advantages and difficulties of engaging in collaborative efforts, particularly among organizations that are based in different geographical areas of the United States.

Challenges being faced in immigration advocacy work

Fifty-five percent of respondents said they were not facing challenges in their immigration advocacy work, while 45% responded that they were. The primary challenges were largely

influenced by the political leanings of the locations in which they were based. These are described in more detail below:

A lack of buy-in from the leadership of their organizations. Many respondents said that their leadership did not want them to engage in advocacy work because they were fearful of getting involved in immigration-related issues, expressed antipathy towards immigrant issues, and/or lacked a general understanding of how immigration issues related to the work of their organizations.

Fear of attracting unwanted attention to immigrant clients and patients. Many health centers expressed concern about how advocacy around immigrant issues would affect their patients and their ability to serve immigrants. In the words of one interviewee:

But even before public charge came out, [a state representative] visited one of our health centers and asked the CEO to talk about our payer-mix, and then questioned our uninsured number, and asked if under that uninsured number those were undocumented people we were serving. So, that made us nervous because, first of all, we don't ask patients what their status is, but the fact that [they were] making that point and asking that question so specifically, and again, this is even before public charge came out, it makes us nervous to think what [they] might be wanting to do, and how that would affect our patients... And under the uninsured population, that could be people that fell through the coverage gap or they just can't afford insurance so they opt to pay out-of-pocket, you know, there's other situations, it's not like they're all undocumented, but [they] did raise the question, and looking into it, yeah, it's true, we do serve undocumented people, we just don't ask. So, we don't know how many we're actually serving.

Some organizations felt that remaining silent about the fact that some of their patients were immigrants was a way of protecting them, and that making it known that they serve an immigrant population could potentially cause more harm. Other participants also noted that some patients became more frightened about their situations after receiving more information.

Restrictions on advocacy for 501(c)(3) organizations and/or federal grant recipients. Many participants, particularly community health centers, said that they did not want to engage in advocacy for fear of losing federal funding and/or jeopardizing their 501(c)(3) status. A lack of understanding of where the line is drawn between advocacy work and taking action to protect their patients was a common concern.

Many of these concerns were more acute for organizations located in more conservative states so strategies must reflect the diversity across the country. The need to tread carefully around immigration issues and the need for more diverse messaging was noted by participating organizations. One interviewee stated the following:

...as a swing state... [we have] gained a lot of credibility of bipartisan work...and so despite what our individual sort of politics might be, as an organization we do stay pretty middle of the road with how we manage things. And so I don't necessarily think that what the workgroup, or what the California PCA has put out has been problematic in that larger sense, but that will probably inform how we participate and even the answers that I was able to give you about like an immigration agenda, which we don't outwardly have...

According to this organization, advocating for immigrant patients would lead to a loss of credibility as a bipartisan organization. Another interviewee added that:

...there's a lot of political tension...and we're definitely right now a red state, so trying to walk that fine line for us is hard you know, sometimes the messaging that comes out of the

workgroup is a little more blue leaning, and we're hesitant to use some of that messaging sometimes because it might be too aggressive for some of our legislators, and we have to be careful and make sure we keep both parties in mind, not just one or the other. So, I think...just recommending that you keep that in mind, we're not all blue states, and we're not all as progressive as California or others may be, so it would be helpful to get more neutral messaging out sometimes.

As this participant explained, state politics are important in terms of how issues and messages are framed. Different legislators must be sensitive to different forces and factors, and what works in more progressive states will be vastly different from what is effective in conservative states. Interestingly, however, when asked about what their organization's priorities were regarding immigration or immigrant patients, a very significant proportion, particularly those based in more conservative locations, indicated that they did not have one. This was particularly surprising given that many stakeholders participated in the NHCIW due to their existing immigrant patient population. Further, the immigrant population is comprised of individuals with many different immigration statuses, not only those who are undocumented.

Positive Aspects of the NHCIW

In the interviews, organizations identified several major positive aspects of the NHCIW, including:

Access to reliable and timely information from legal experts that could be incorporated into their work. Most interviewees said that a major benefit of participating in NHCIW was the quality and timeliness of the webinars, particularly in the current and rapidly evolving policy and political environment. For instance, one interviewee said:

...being able to give people solid information is validating and soothing...I think that people operate from a better place when they're not in fear, and they don't have misinformation and they don't have just a rumor mill going. As in the providers, the receptionist, and then how they're able to make that message relate to the patient. And so that's ultimately what I believe has been a huge benefit as I've come on to this group at the end, is balancing out and combating against, what I believe is intentional rumors and fear that's created, in order to have people respond a particular way that may not be in their best interest.

Interview respondents consistently praised the practical nature of the resources produced by NHCIW, including the timeliness of webinars and the benefits of receiving accurate information, particularly from legal experts. Survey participants also attested to the value and usefulness of NHCIW resources, including advocacy toolkits, 330 grant advocacy information, and immigration sample policies and procedures to make health centers safe for immigrant patients.

The Focus on health care and health centers. This focus was noted by many as being a “value add” of NHCIW compared to many other coalitions and organizations engaging in similar work. One interviewee summarized this positive aspect of NHCIW:

I think having the information sharing piece is definitely vital...I think that there are other organizations or other coalitions that are also doing work in this space. I think what's unique to what is happening through the Health Center Immigration Workgroup is the particular focus on health center issues or questions...being able to protect patient privacy is an issue that comes up and you know, and what is a public space versus what isn't? And you know, are health centers considered the so-called sensitive locations? What about HIPAA? Or EHR? So, I think the information sharing that goes on, that is more specific or unique to

health center organizations is definitely where there's more value add for what the workgroup is doing.

Although multiple groups focused on similar work, having information specific to patients and health centers.

Mission and Purpose of NHCIW

Across the interviews, several suggestions for the long-term mission and purpose of the NHCIW emerged:

Keeping health centers informed on issues faced by immigrant patients and how to improve their ability to serve them. This was viewed as particularly important given the expectation that federal policies that negatively affect immigrant patients will continue to be developed, and the important and unique role that health professionals can play in influencing policy because they have credibility that other organizations and stakeholders may not.

Advocacy. Priority issues for advocacy were removing immigration status as a barrier to primary care access and working towards ensuring that all immigrants have access to health care and coverage.

Leadership development. As noted above, some participants expressed that leadership in their organizations was not supportive of their engaging in immigration advocacy-related work. Given the lack of leadership buy-in faced by many organizations, participants indicated the need for a leadership-building focus, which would also help develop skills and capacity that could strengthen other facets of their work.

Opportunities for more meaningful engagement other than advocacy. This was a prominent theme, given that member organizations had varied ideas of what advocacy entails, and the

restrictions that limit health centers from engaging in advocacy given their status as 330 grant recipients and 501(c)(3) organizations. Some interviewees saw broadening the agenda of the group as a key strategy to address the concerns in their organizations about engaging in advocacy and/or lack of interest in immigrant issues. Some examples of other potential issues to focus on included leadership development that could be wrapped around existing immigrant work. In the words of one interviewee:

I think that when we address those pieces too, that is also a way to get our c-suite or our admins buy-in, in terms of saying that this work is not just about organizing projects about advocacy, it translates into many other facets of the work...related directly to the day-to-day work that we do with our patients and our communities.

Making a clear distinction between advocacy work and the activities of the NHCIW, as well as including additional sub-topics beyond how to protect immigrant patients (given that some leadership were not in support of their staff engaging in immigration-related work) are necessary for leadership to approve continued staff participation.

Areas for Improvement for NHCIW

Interviewees had many suggestions for how NHCIW could improve its work. The most prominent ones are summarized below.

A desire for increased participation and collaboration among participants. This was a common theme. In particular, the interviewees wanted to hear from other health centers and primary care associations about current issues and share expertise and best-practices in addressing various issues. Participants articulated that increased dialogue would enable the NHCIW to be less reactive by being able to identify issues before they receive national attention

and be better prepared to tackle them. One interviewee said, “...*I would like the workgroup to be more bi-directional in terms of the communications...I think at the long-term, states reporting out potential threats and trends is critical, if this is something that can be cultivated*”. This participant articulated that, ideally, states would be able to alert organizations nationwide about issues arising in their state to better prepare, particularly if it is something that could become a more widespread issue.

Take greater advantage of the potential to use the NHCIW as a mechanism to develop a unified agenda and voice across health centers and primary care associations (PCAs). Some participants saw potential for NHCIW to be a means of enabling health centers to speak and advocate for a similar agenda, particularly with decision-makers. One interviewee expressed that:

...the workgroup needs to strategize and to really provide a unified voice...we are already hearing different people say different things where you know, it becomes unintentionally divided, like, “well, oh don’t cut this group...”, and overall we should be saying, ‘don’t let any immigrants fall off,’ let’s make sure that our state officials really are thinking about ways to cover the gaps as they come, or else our safety nets will get hit pretty hard and we may not recover...So making sure that we have a unified agenda when we’re talking, so that it doesn’t become just this free for all, trying to fight for certain groups that we are working towards...

Different organizations have different needs and visions, and a lack of a common agenda on which all organizations could agree led participating membership to focus on their particular target populations, as opposed to the larger collective.

Lack of consensus about NHCIW messaging and materials. Although 72% of individuals surveyed reported that they were comfortable with the messaging in the materials shared by the NHCIW, 28% indicated that they were not comfortable. Common reasons for discomfort included:

- Some materials had an advocacy focus, which is not appropriate for 501(c)(3) organizations and/or federal grant recipients which are not permitted to engage in advocacy. Although participants appreciated the importance of advocacy materials, they noted a need for resources and materials that do not combine advocacy and education.
- Materials were not adequate or effective or appropriate for using with more conservative elected officials.
- Participants wanted materials that use simpler language and be more consumer-friendly for patients and other audiences.

Next Steps and Recommendations

Based on the interview results, the following recommendations were developed for NHCIW:

- Allow space for dialogue and greater participation during calls. Respondents expressed a desire to learn more from other health centers, PCAs, and experts from different sectors. A few participants also mentioned that the workgroup currently lacked a “workgroup identity” due to few opportunities for engagement.
- Create sub-workgroups. Identify individuals working on immigrant issues at various health care centers and PCAs and invite them to participate in NHCIW sub-workgroups (based on issue areas, geographical location, or political environment for example). This was a recommendation offered by some participants to create a more inclusive environment while managing the diverse needs of its members.

- Tailor resources and messaging to diverse stakeholders. The NHCIW should work towards adapting its resources to meet the needs of participants living in more conservative states. Messaging as being “blue-leaning” or inadequate for more conservative states was a key issue discussed in both surveys and interviews.
- Clarification on rules for 501(c)(3) advocacy. Separate information and advocacy materials, and provide additional resources and education on the appropriate advocacy actions for 501(c)(3) organizations and/or federal grant recipients; this was highlighted as an issue or concern by many participants and their leadership.
- Maintain a health care focus on all issues discussed and incorporate skills-based components. This will allow participants to justify their involvement as members in the NHCIW, particularly for those whose leadership may be hesitant to engage in immigration-related issues and/or advocacy work alone.
- Create and promote a unified agenda. The NHCIW should promote a unified agenda around increasing access to health care for all immigrants, rather than subpopulations within this category, in order to ensure that all immigrants are equally protected while respecting the political concerns of health centers and PCAs around the country. Respondents described the need to create a unified agenda to inform the NHCIW’s mission and purpose in a participatory way as important, while ensuring that no one immigrant group was highlighted or excluded.

Overall, participants expressed a desire for the NHCIW to serve multiple roles and functions. These include: monitoring policies and their impact on immigrant patients; serving as a source of accurate information; providing, a space to share concerns, experiences, and expertise; and being

a place where members can receive training and skills to further validate their continued participation. Given the diverse range of participating organizations, however, it is evident that creating a unified agenda and adequate messaging has been particularly challenging because of variation in the political environment across states, and that this has inhibited collaboration across organizations. However, participating organizations saw many opportunities to build on NHCIW's work to date, and to expand its reach and impact.

THE NATIONAL COLLABORATIVE FOR HEALTH EQUITY

To complement the work I did for the Department of Health and CPCA, I also collaborated with the National Collaborative for Health Equity throughout 2019, working on its Health Opportunity and Equity (HOPE) Initiative.

The National Collaborative for Health Equity, which was founded in 2014, is a national organization focused on harnessing evidence and creating partnerships across sectors, with the intent of promoting policies and practices that will elevate opportunities for health equity. The National Collaborative for Health Equity defines health equity as creating the conditions that will allow all populations, regardless of race, ethnicity, socioeconomic status, or nativity, the opportunity to have the best possible health. It believes that addressing structural, institutional and interpersonal injustices created by racism is vital to move towards health equity. The Collaborative works with many individuals and organizations that seek to advance health equity, including the Build Healthy Places Network, CommonHealth Action, American Public Health Association, Health Equity Leadership & Exchange Network, W.K. Kellogg Foundation, Robert

Wood Johnson Foundation, the National Association of County and City Health Officials (NACCHO), and the Association of State and Territorial Health Officials (ASTHO).⁴

The Health Opportunity and Equity (HOPE) Initiative

The HOPE Initiative, funded by the Robert Wood Johnson Foundation, measures and tracks 28 health equity indicators at the state level, across 6 domains; these include health outcomes, socioeconomic factors, the social environment, physical environment, and access to health care. In addition to measuring and tracking health equity indicators, the HOPE Initiative provides information and state-level rankings, and national comparisons. The purpose of the HOPE Initiative is to highlight states' opportunities for health and guide them towards health equity, by setting benchmarks, or HOPE Goals, based on high-performing states across different indicators.

Goals of Project

In collaboration with the HOPE Initiative, I produced three policy briefs, based on existing secondary sources, on state and local best practices for promoting health and reducing health inequities. The topic areas for the briefs were housing (including affordable housing and quality housing), low-poverty concentration, and health care access (including primary care, usual source of care, affordable health care, health insurance coverage, colorectal cancer screening, mental health care, and implicit bias).

The goal of the policy briefs was to foster cross-sector dialogue and action, and the intended audiences are decision-makers, advocates and people working outside of public health. The briefs were intended to be a resource for individuals seeking information on specific issues that

⁴ Additional information is available on the National Collaborative for Health Equity website (<https://www.nationalcollaborative.org/about-us/>).

influence health outcomes, including background information, actionable evidence-based practices, and current examples of work that states are doing to address each issue.

Methodology

The methodology for each brief was distinct, given varying levels of evidence and information on each topic. One major source of information was the County Health Rankings & Roadmaps, a Robert Wood Johnson Foundation initiative which ranks the existing evidence of the effectiveness of applied policies, programs and systems change to address social determinants of health. The rankings range from “evidence of ineffectiveness” to “scientifically supported” (County Health Rankings & Roadmaps, n.d.). Once evidence-based interventions or best practices were identified for each issue area, practical examples of how states are addressing each issue were incorporated. The briefs were structured in the following way:

1. background information on the issue, including how it influences health;
2. inequities based on race, income and education;
3. best practices for addressing the issue; and
4. practical applications based on action steps states have taken to address the issue.

It is important to note that not all practical applications highlighted are evidence-based because some states have engaged in innovative work that has not been evaluated. The practical applications section of each brief is designed to highlight different ways in which states are trying to improve their performance on different health equity indicators.

The briefs, which are still being finalized by the National Collaborative for Health Equity, will be used to populate content on the HOPE website.⁵

Lessons Learned

This project differentiates from the two previously discussed projects in that qualitative data was not collected to meet the goals of this project. Additionally, while the other projects directly engaged with stakeholders and more directly touched on the challenges of multi-sector collaboration to advance health equity, this project focused on using secondary data to then translate information and make it accessible and actionable for a wider, multi-sector audience.

The following are some lessons learned that can help inform future work:

- When discussing issues and state-level policies that contribute to health equity, it is necessary to consider state diversity. This includes using language that does not alienate audiences with varying policy perspectives, while highlighting a diversity of examples nationwide. Such diversity includes rural versus urban composition, varying political leaning, and differences in population demographics. All states have strengths and areas of opportunity to further improve health for all.
- When describing factors that influence health opportunity, it is important to frame them in a way that allows individuals outside of the health sector to understand how their role contributes to health outcomes and health equity. Similarly, recommendations should be presented in an actionable way.
- When creating linkages between health outcomes and social determinants of health for non-public health audiences, it is essential to use language that is accessible to all

⁵ Additional information is available on the HOPE (<https://www.nationalcollaborative.org/our-programs/hope-initiative-project/>).

irrespective of their background and training. This includes avoiding the use of very technical language or public health jargon.

Making information both accessible and inclusive is fundamental to ensure issues and potential solutions are easier to grasp by non-public health audiences, leaving the reader with actionable steps for how their state can seize opportunities to improve on different health equity indicators. Furthermore, to portray a diversity of approaches, a conscious effort was made to include examples from states with large urban and rural areas, as well as states with varying political leanings.

THEMES ACROSS PROJECTS

The objective and final product for each of the projects, though different, allowed me to explore the use of multi-sector collaboration to advance health equity, and helped elucidate the challenges of engaging in such work. Some of the common themes that arose across all projects included: messaging and communication about social issues; managing politics at the federal and local levels; and funding and the ways in which funding can incentivize multi-sector work.

STRATEGIC MESSAGING

Among stakeholders interviewed for the Department of Health, the messaging or way in which health equity is described and communicated was a key theme that arose. Stakeholders had differing views of the meaning of health equity, which not only highlighted the importance of creating a unified vision of what health equity means, but also, more importantly, drew attention to the fact that different sectors influence health and can impact health equity. Several stakeholders also mentioned the need to frame health equity using a framework such as the collective impact model, to allow diverse sectors and organizations to understand the importance of aligning their work as they collaborate to influence health outcomes.

Meanwhile, stakeholders involved in the strategic planning process for CPCA's National Health Center Immigrant Workgroup were concerned with how best to craft a clear message that would allow them to advocate effectively for the health needs and rights of immigrant communities. Individuals who were part of the National Health Center Immigrant Workgroup described the importance of messaging both in terms of ensuring that patients, regardless of their immigration status, were not excluded from advocacy efforts, while maintaining political neutrality, given that many organizations are based in more conservative parts of the country. Stakeholders in more conservative states were concerned that their immigrant patients and the health centers that serve them could suffer harmful unintended consequences if messages were not carefully crafted, and many felt that it was best to keep a low profile. Additionally, ensuring that the messaging of the workgroup was not too politically charged was necessary to encourage the open involvement of stakeholders across the country.

The ways in which social issues are communicated was also considered when creating policy briefs for the National Collaborative for Health Equity. Writing these briefs in simple language that is easy to understand by diverse audiences and non-public health professionals was considered very important, since these materials will also be utilized by individuals outside of the health field. For all collaborating partners, particularly those in sectors not directly providing health care, it is important to clearly articulate the connections between their interests/issues, and health; these partners must have a clear understanding of how issues such as sub-standard housing and poverty influence health outcomes and have an impact on health equity. Additionally, issues in the policy briefs were framed within the context of race, education, and income, as these are key aspects of health equity, and discussing differences in health outcomes and access to health across these three characteristics is important.

Overall, it was key to develop and use a common language that allowed individuals to understand what health equity means, and how their work contributes to the mission of improving equity, while being inclusive of all individuals, and enabling the participation of diverse stakeholders within different political environments.

THE IMPACT OF POLITICS

Given the nature of the Department of Health as a local government agency, the issue of politics was an underlying topic during stakeholder interviews. Stakeholders' willingness to engage in collaborative work with the department were often influenced by their relationships with local government, in general. Stakeholders that were grantees tended to have more positive views of the work that the Department of Health was doing and reported more positive experiences. Meanwhile, service providers that were reimbursed by the Department of Health or whose work was monitored by the Department of Health, felt that the fragmentation of local government, led to inefficiencies, and conflicting requirements. Furthermore, stakeholders articulated that local government should model multi-sector collaboration to enable and incentivize organizations to do so as well. The stakeholder interviews, highlighted the importance of the preexisting relationships between government and local organizations, and the need to balance power dynamics, as such relationships were influenced by requirements and regulations imposed to receive funding for example. Furthermore, because local government may have leadership changes every few years, it is difficult to maintain and foster long-term relationships.

For CPCA's project, the issue of politics was very prominent, particularly because the National Health Center Immigrant Workgroup gained significant traction after the proposed changes to the public charge rule were released by the federal administration. Fear due to the

politics surrounding immigrant communities and their right to resources was extremely pervasive, both at the staff, organizational, and patient levels. Some staff indicated a lack of support of immigrants by leadership in their organizations due to personal views, while others indicated their leadership's desire to keep their work with immigrant patients under a low profile for fear that their state legislators might take action against health centers that would harm their patients. Further, some organizations and/or health centers were afraid of engaging in advocacy work overall given their status as federal grant recipients which imposed limitations on their ability to engage in advocacy work. Stakeholders also discussed that immigrant patients were, in general, operating under immense fear, and though providing accurate information was critical given all the existing misinformation, some patients were triggered by conversations regarding their rights and potential risks if changes, such as those of the public charge rule went into effect. Ultimately the need to tread carefully around issues related to immigration with patients, their organizational leadership, and with their representatives was highlighted by most research participants. This project highlighted how politics at the federal level trickle down to the local level, as well as how challenging it is to engage in collaborative work at the national level with organizations where the leadership spans the political spectrum.

For the policy briefs done for the National Collaborative for Health Equity, a conscious effort was made to highlight activities in states across the political spectrum, and ensure that states were not alienated based on varying state characteristics. This was particularly important since all states have opportunities to improve health outcomes, while innovative work on issues that influence health equity is being done nationwide. The organization stressed that diversity is not just a matter of political leaning, but also includes the range of rural and urban settings, race/ethnicity, and socioeconomic settings.

MANAGING FUNDING

Funding was an issue prominently discussed among stakeholders interviewed for the purpose of this project. Interviewees were directly asked about barriers to multi-sector collaboration, and funding was one of the critical challenges described to engaging in such work. In general, many organizations are under-resourced and must prioritize their primary scope of work, limiting the time spent on work that is more collaborative in nature. Some stakeholders also highlighted that the ways in which funding was provided influenced how organizations used those resources, and thus using funding to incentivize multi-sector collaboration is one way of promoting that work. One stakeholder discussed that a funding source had previously led to multi-sector collaboration by requiring organizations to come together to work towards addressing one specific issue.

Funding is not a topic that arose directly within CPCA's project. However, the National Health Center Immigrant Workgroup initiated under CPCA's leadership to contract with a legal organization to develop sample policies for health centers to protect their immigrant patients in the event of an immigration raid. CPCA shared those resources with other primary care centers across the country and asked for donations given the high cost of developing such materials, which garnered sufficient resources and allowed the organization to realize that this was an important need by health centers nationwide. This led to a partnership among CPCA, AAPCHO and NACHC to develop resources and materials to help health centers across the country address various immigration-related issues. This enabled the organization to generate resources that could be used toward the mission of the workgroup. Incentives were also a theme that arose among other participating organizations, indicating that additional incentives, such as leadership

development, were important to sustain their continued participation in the workgroup, and justify it to their leadership.

Although funding was not a central theme of the work done for the National Collaborative for Health Equity, funding sources used by states were incorporated onto the policy briefs, where applicable, to highlight how funding sources could be utilized to help achieve the HOPE Goals. The intent is that this information will help advance health equity while increasing knowledge about the impact different sectors have on health and health equity overall.

CONSIDERATIONS FOR MULTI-SECTOR EFFORTS TO ADVANCE HEALTH EQUITY

The following frameworks illustrate the foundational elements that can enable organizations, and state and local governments to advance health equity through multi-sector collaboration.

FOUNDATIONAL ELEMENTS TO INITIATE MULTI-SECTOR COLLABORATION

The foundational elements to initiate multi-sector collaboration include a long-term commitment to advance health equity, incentives and funding, and leadership.

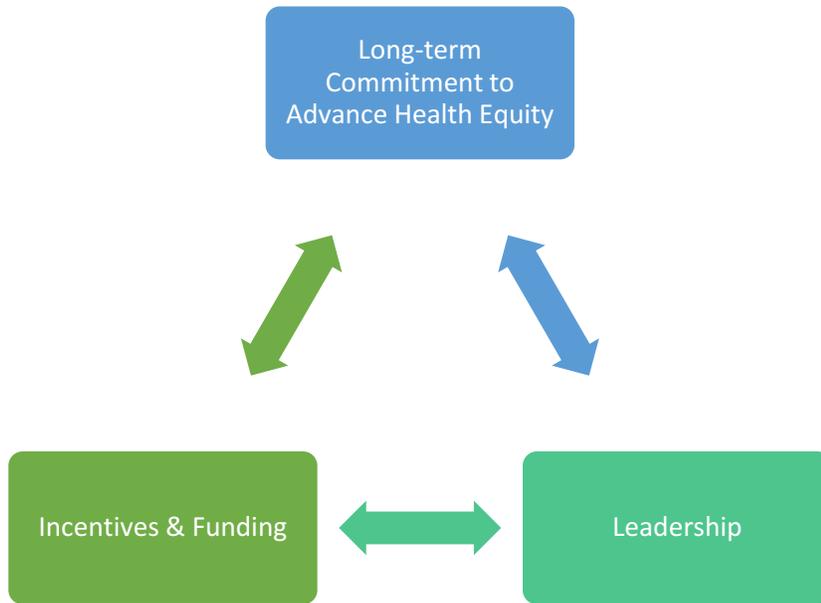


Figure 1: Foundational Elements to Initiate Multi-Sector Collaboration

Long-Term Commitment to Advance Health Equity

Although advancing health equity is not something that can be achieved in the short-term, progress in reducing health inequities can be made through short-term actions. The reduction of health inequities is an inherently complex and “wicked” problem. Improvements should be viewed as a process and not just an end goal. Leadership, organizations involved, and sources of funding must be aware of the long-term nature of this process and should be committed to that work and its sustainability for it to be successful.

Incentives and Funding

It is difficult for organizations, agencies and sectors that are overtaxed and have limited resources to dedicate time to multi-sector collaboration, particularly if that work is not directly aligned with their priorities or areas of focus. Further, engaging in multi-sector collaboration can be time- and resource- intensive for which adequate incentives and long-term funding are important. Funding for multi-sector collaboration is necessary for the sustainability of these

efforts, particularly if it allows for dedicated staff to partake in that effort. Such incentives require government and foundations to fundamentally change the notion of their role, from one that funds a single organization, to one that is invested long-term in achieving social change, “...funders must help create and sustain the collective processes, measurement reporting systems, and community leadership that enable cross-sector coalitions to thrive” (Kania & Kramer, 2011, p.41).

Stakeholders interviewed for the Department of Health indicated the value of providing grant money for organizations to work with one another toward a common goal. It is also important to support the long-term participation of organizations by capitalizing or expanding on work that is currently being done to improve health outcomes or other social determinants of health.

The incentives for participation must be considered valuable and appropriate to collaborating organizations in order for them to remain committed over time. For instance, organizations involved in the National Health Center Immigrant Workgroup pitched training and staff development that could incentivize leadership to allow the organization to continue being engaged, particularly if such training can be used by organizations in other facets of their work. State and local government leadership that seeks to promote multi-sector collaboration can also incentivize or require government agencies or departments to work with one another and model this behavior for other organizations.

Leadership

Having a leader or set of leaders with external legitimacy can bring knowledgeable and essential stakeholders to the collaborative. As discussed in previous sections, stakeholders help define the problem, and are necessary for the development of innovative solutions. Leaders

should also be involved in creating equitable representation and ensuring that those most affected by the problem being addressed have a seat at the table.

NECESSARY ELEMENTS FOR THE SUCCESS OF MULTI-SECTOR COLLABORATION TO ADVANCE HEALTH EQUITY



Figure 2: Necessary Elements for the Success of Multi-Sector Collaboration to Advance Health Equity

Create a Coalition of Diverse Stakeholders

A coalition of stakeholders from diverse sectors, with diverse perspectives and with knowledge of the problem being resolved is necessary to help create solutions that are fully informed and more likely to be successful. Stakeholders that are knowledgeable on the issue include people that are directly impacted by the problem being addressed.

To achieve diversity in participating stakeholders, it is important to include organizations from across sectors, including organizations or stakeholders whose line of work influences (albeit indirectly) the problem, such as housing and education. It is also invaluable to include diverse organizational sectors, such as community-based organizations, government agencies, academic institutions, etc.

Further, it is important to be cognizant of local politics as well as existing relationships among groups, and how such politics may influence stakeholder participation. For instance, stakeholders interviewed for the National Health Center Immigrant Workgroup that are based in more conservative states indicated that their participation was limited due to the politics of the regions in which they operate. Some of the resources that came out of their workgroup were less effective for advocating for their patients in such political environments. Stakeholders interviewed for the Department of Health indicated they were more or less likely to participate and engage in multi-sector collaboration based on pre-existing relationships with local government. Mitigating some of those challenges is necessary to ensure that all who need to be engaged are encouraged to do so.

As previously discussed, equity should also be considered in how such efforts are structured; it is essential to include organizations or stakeholders who can lift the needs of more marginalized groups of people.

Diverse stakeholders can also be encouraged to participate via incentives and by taking advantage of work that has already been initiated, such as meeting in places where organizations are already engaging to avoid replicating the wheel.

Develop a Unified Mission and Purpose

A unified mission and purpose are important to ensure that all stakeholders are on the same page and are equally knowledgeable of the objective for which they are collaborating. All stakeholders involved in the multi-sector collaborative effort should share a common language and understanding of what it is they are trying to achieve.

Adequate messaging is critical for this aspect of the collaborative project for organizations to understand what health equity means, how their work influences it, and what their overarching goal is. This will require education on how the work of multiple stakeholders and sectors contribute to health outcomes and how health inequities are reproduced. Moreover, stakeholders should also come to understand the interconnectedness of their fields and begin to understand collaboration as necessary to make significant progress. This can also be achieved by utilizing the collective impact model or similar frameworks to help guide multi-sector collaboration and educate stakeholders on its value.

Establish Shared-Power Processes

For a multi-sector collaborative effort to be successful, it is important to establish shared-power processes. To achieve this, transparency and trust among participants is essential. Everyone should have an equal opportunity to share perspectives, and establishing an inclusive decision-making process is vital. All participating stakeholders should feel comfortable sharing their perspectives, even if those differ from perspectives previously shared, and all views should be taken into consideration in the decision-making process. Tracking decisions and agreements made can help generate a more transparent process to ensure all decisions are documented. Further such agreements, though open to change, can serve as mechanisms for accountability of all stakeholders.

Leaders play an important role in establishing shared-power processes. The purpose of leaders in multi-sector collaboration should not be to dictate what needs to be done, but rather to help develop additional leaders who can help move the collaborative efforts forward, and transfer leadership to others as deemed appropriate.

Ensuring that everyone has an equal opportunity to share their perspectives within a meeting can be challenging. However, this can be addressed by creating smaller sub-groups within the multi-sector collaborative to ensure that everyone's voices are heard, and a consensus can more effectively be reached. This is also important to help balance power differences, and ensure that everyone, particularly those with less power, have more opportunities to engage in dialogue.

Collect and Share Data to Track Progress

Data on indicators of interest are important to help track and determine whether progress has been made. Many organizations collect and analyze data that can help inform the work of the multi-sector collaboration. If multi-sector collaboration is initiated at the state or local government level, having shared data across departments or agencies can help stakeholders understand the full picture. Data sharing can also help inform how various sectors influence the issue being addressed.

Monitoring data throughout the collaborative effort enables the identification of short-term progress or smaller wins that can continue to fuel and mobilize the work done via multi-sector collaboration. Additionally, such data can be useful to identify existing gaps and areas of opportunity to make more meaningful impacts.

Evaluate, Adapt and Innovate

As new information becomes available, it will be necessary to make changes and create a continuous cycle of improvement that will allow multi-sector efforts to get closer and closer to their objective. Further, as more information becomes available or additional participants join the effort, engaging in the development of innovative ideas will help prevent inertia as stakeholders strategize to make greater improvements or more meaningful change.

For instance, the stakeholders interviewed for the National Health Center Immigrant Workgroup indicated that some of the resources were not adequate to influence positive change in their communities. They suggested creating smaller workgroups with the same goal in mind, but that could adapt the resources produced to better serve their needs and their political reality. Finding ways to continuously make improvements and changes that will encourage and enable the participation of all members is vital for both the sustainability and success of the multi-sector collaboration. Using a design-based approach towards addressing a problem, rather than a solutions-based approach can help the adaptation and innovation process. Multi-sector collaboration should not be married to one solution or one way of addressing the problem.

Amplify Progress and Small Wins

It is important to celebrate progress and small or short-term wins. This will help generate momentum, while allowing all participants to see that they are collectively making progress. As previously discussed, it is necessary to view health equity as a process rather than an end goal. Achieving health equity is extremely hard and will not be achieved in the near future. Though health equity should be the overarching goal, it should be viewed as a process and one through which organizations are moving closer and closer towards achieving health equity for all.

Further, it is important to capitalize on progress made to mobilize additional progress and enable more widespread change.

Reduce Health Inequities

Ultimately all of these efforts should enable health inequities to be ameliorated and allow for the advancement of health equity. Progress in the reduction of health inequities allows for the evolution of the problem definition and the increasing participation of additional stakeholders, adaptability and innovation of existing processes.

Equity

Equity should be the common thread and unifying theme across all stages and work processes of multi-sector collaboration, and a consideration of the equity implications should be the backbone of all decisions made. For instance, some organizations have incorporated a racial equity lens by establishing a racial equity expert in all organizational departments to flag potential negative outcomes as well as opportunities to improve racial equity.

Health equity is influenced by multiple intersecting factors, so much so that societal inequities play an important role in health outcomes and health equity. Addressing racial, economic and educational inequities will contribute to better health outcomes overall.

CONCLUSION

The various projects I engaged in for my doctoral thesis were still in the planning phases of their multi-sector collaboration efforts. Nonetheless, they offered some insights into how organizations operate and allowed me to build on my understanding of multi-sector collaboration based on existing literature. Ultimately, incentives or funding are critical particularly when engaging with community-based organizations that may not have sufficient staff capacity or resources to be active participants, or for which outside funding is critical to get leadership buy-

in. A unifying message is also important for all collaborative efforts, but health must rely extensively on multi-sector collaboration given that many of the social determinants of health are outside the control of the health sector. This means that all stakeholders must have a good understanding of the role their work plays on health outcomes while also seeing value in working towards advancing health equity. Additionally, though less mentioned in the literature, politics play a very important role. Given that health outcomes are influenced by structural resources and power, many social determinants are inherently political, and therefore are influenced by federal, state and local policies and politics.

BIBLIOGRAPHY

- Ansell, C., & Gash, A. (2008). Collaborative governance in theory and practice. *Journal of public administration research and theory*, 18(4), 543-571.
- Wyss, K., Dolan, K., Goff, N. (n.d.) Health in All Policies: A Framework for State Health Leadership. Association of State and Territorial Health Officials (ASTHO). Retrieved from <https://www.astho.org/HiAP/Framework/>.
- Baker, E. A., Metzler, M. M., & Galea, S. (2005). Addressing Social Determinants of Health Inequities: Learning From Doing. *American Journal of Public Health*, 95(4), 553–555.
- Bingham, L. B. (2009). Collaborative governance: emerging practices and the incomplete legal framework for public and stakeholder voice. *J. Disp. Resol.*, 269.
- Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. (2017). What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation.
- Bryson, J. M., Crosby, B. C., & Stone, M. M. (2006). The design and implementation of Cross-Sector collaborations: Propositions from the literature. *Public administration review*, 66, 44-55.
- Bryson, J. M., Crosby, B. C., & Stone, M. M. (2015). Designing and implementing cross-sector collaborations: Needed and challenging. *Public Administration Review*, 75(5), 647-663.
- Emerson, K., Nabatchi, T., & Balogh, S. (2012). An integrative framework for collaborative governance. *Journal of public administration research and theory*, 22(1), 1-29.
- Erickson, D., & Andrews, N. (2011). Partnerships among community development, public health, and health care could improve the well-being of low-income people. *Health Affairs*, 30(11), 2056-2063.
- Erickson, J. (2018, January 30). Multisector Partnerships Have the Potential to Transform Health, but Most Aren't There Yet. Retrieved from <https://www.rethinkhealth.org/Resource/multisector-partnerships-have-the-potential-to-transform-health-but-most-arent-there-yet/>.
- Flood, J., Minkler, M., Hennessey Lavery, S., Estrada, J., & Falbe, J. (2015). The collective impact model and its potential for health promotion: overview and case study of a healthy retail initiative in San Francisco. *Health Education & Behavior*, 42(5), 654-668.
- Glouberman, S., & Zimmerman, B. (2002). Complicated and complex systems: what would successful reform of Medicare look like?. *Romanow Papers*, 2, 21-53.
- Gray, B. (1989). Finding common ground for multiparty problems. *The josseybass social and behavioral science series*.
- Gray, B., & Purdy, J. (2014). Conflict in cross-sector partnerships. In *Social Partnerships and Responsible Business* (Vol. 205, No. 225, pp. 205-225). ROUTLEDGE in association with GSE Research.

- Hearld, L. R., Bleser, W. K., Alexander, J. A., & Wolf, L. J. (2016). A systematic review of the literature on the sustainability of community health collaboratives. *Medical Care Research and Review*, 73(2), 127-181.
- Heifetz, R. A., Kania, J. V., & Kramer, M. R. (2004). Leading boldly. Stanford Social Innovation Review. Retrieved from https://ssir.org/articles/entry/leading_boldly.
- Innes, J. E., & Booher, D. E. (2018). *Planning with complexity: An introduction to collaborative rationality for public policy*. Routledge.
- Institute for Clinical Systems Improvement. (2014). Going Beyond Clinical Walls: Solving Complex Problems. Robert Wood Johnson Foundation. Retrieved from https://www.icsi.org/wp-content/uploads/2019/08/1.SolvingComplexProblems_BeyondClinicalWalls.pdf.
- Kania, J., & Kramer, M. (2011). Collective Impact. Stanford Social Innovation Review. Retrieved from https://ssir.org/articles/entry/collective_impact#.
- Koliba, C. J., Mills, R. M., & Zia, A. (2011). Accountability in governance networks: An assessment of public, private, and nonprofit emergency management practices following Hurricane Katrina. *Public Administration Review*, 71(2), 210-220.
- Koschmann, M. A., Kuhn, T. R., & Pfarrer, M. D. (2012). A communicative framework of value in cross-sector partnerships. *Academy of Management Review*, 37(3), 332-354.
- Lasker, R., Weiss, E., & Miller, R. (2001). Promoting collaborations that improve health. *Education for health*, 14(2), 163-172.
- Morse, R. S. (2010). Integrative public leadership: Catalyzing collaboration to create public value. *The Leadership Quarterly*, 21(2), 231-245.
- National Academies of Sciences, Engineering, and Medicine. (2017). *Communities in action: Pathways to health equity*. National Academies Press.
- National Immigration Law Center (NILC). (2020). Changes to Public Charge: Analysis and Frequently Asked Questions. Retrieved from <https://www.nilc.org/issues/economic-support/pubcharge/changes-to-public-charge-analysis-and-faq/>
- Nweke, O. (2017). A Roundtable on Cross-Sector Collaboration and Resource Alignment for Health Equity: Meeting Summary. *Journal of Health Disparities Research and Practice*, 9(6), 95-103.
- Ollila, E. (2011). Health in all policies: from rhetoric to action. *Scandinavian journal of public health*, 39(6_suppl), 11-18.
- Pittz, T. G., & Adler, T. (2016). An exemplar of open strategy: Decision-making within multi-sector collaborations. *Management Decision*.
- Provan, K. G., & Kenis, P. (2008). Modes of network governance: Structure, management, and effectiveness. *Journal of public administration research and theory*, 18(2), 229-252.

- Ring, P. S., & Van de Ven, A. H. (1994). Developmental processes of cooperative interorganizational relationships. *Academy of management review*, 19(1), 90-118.
- Rittel, H. W., & Webber, M. M. (1973). Dilemmas in a general theory of planning. *Policy sciences*, 4(2), 155-169.
- Romzek, B., LeRoux, K., Johnston, J., Kempf, R. J., & Piatak, J. S. (2014). Informal accountability in multisector service delivery collaborations. *Journal of Public Administration Research and Theory*, 24(4), 813-842.
- Roussos, S. T., & Fawcett, S. B. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual review of public health*, 21(1), 369-402.
- Siegel, B., Erickson, J., Milstein, B., & Pritchard, K. E. (2018). Multisector partnerships need further development to fulfill aspirations for transforming regional health and well-being. *Health Affairs*, 37(1), 30-37.
- Thomson, A. M., & Perry, J. L. (2006). Collaboration processes: Inside the black box. *Public administration review*, 66, 20-32.
- Towe, V. L., Leviton, L., Chandra, A., Sloan, J. C., Tait, M., & Orleans, T. (2016). Cross-sector collaborations and partnerships: essential ingredients to help shape health and well-being. *Health Affairs*, 35(11), 1964-1969.
- Vangen, S., & Huxham, C. (2005). Managing to collaborate: The theory and practice of collaborative advantage. *Oxon: Routledge*.
- Woulfe, J., Oliver, T. R., Siemering, K. Q., & Zahner, S. J. (2010). Peer reviewed: Multisector partnerships in population health improvement. *Preventing chronic disease*, 7(6).
- Zahner, S. J., Oliver, T. R., & Siemering, K. Q. (2014). Peer Reviewed: The Mobilizing Action Toward Community Health Partnership Study: Multisector Partnerships in US Counties with Improving Health Metrics. *Preventing chronic disease, Centers for Disease Control and Prevention*.

APPENDIX 1

Interview Guide

1. What led you to join the NHCIW?
2. Has the NHCIW met your expectations? Why or why not?
3. What are your organization's current priorities around immigration? How can NHCIW help support these priorities and your work?
4. What is the NHCIW doing well?
5. What are some aspects the NHCIW can improve upon?
6. What should be the long-term mission/purpose of the NHCIW?
7. In addition to public charge, what other issues should NHCIW focus on? Why?
8. How can NHCIW leverage its size and capacity?
9. What role do you think members should play within the NHCIW?
10. How would you like to continue to engage with the NHCIW? And how can NHCIW support you?

APPENDIX 2

Survey

1. What sector/type of organization do you work in (e.g. health center, policy and advocacy organization, academia, etc.):

2. What types of activities (if any) has your organization engaged in around immigration? Check all that apply.
 - Sent letters to representatives regarding:
 - i. DACA
 - ii. Family Separation
 - iii. Public Charge
 - iv. Temporary Protected Status (TPS)
 - Submitted comments on:
 - i. Public charge
 - ii. Flores Settlement Case (relating to Family Separation)
 - Encouraged patients to submit comments on public charge
 - Collaborated with other organizations around advocacy initiatives
 - Have conducted Know Your Rights Trainings
 - Have provided resources to patients and staff
 - Have implemented sample policies and procedures to prepare for an encounter with immigration officials.
 - Other:

3. What additional resources (if any) does your organization need? Check all that apply & fill-in the blank.
 - Template letters targeted towards _____
 - Talking points targeted towards _____
 - Information to disseminate to patients on _____
 - Trainings/webinars on _____
 - Other: _____

4. Are you currently comfortable with the messaging of the materials shared with NHCIW?
 - Yes
 - No
 - If no, why not?

5. Are you experiencing any challenges with increasing your immigration advocacy?

- Yes
- No
- If yes, please explain these challenges:

6. In addition to public charge, what other immigrant issues should the NHCIW focus on?

- DACA
- TPS
- Family Separation
- Migrant workers
- Other _____

7. What aspects of the NHCIW have been most useful?

- CPCA Immigration Resource Page
- Public Charge Advocacy Toolkit
- Know Your Rights information
- Immigration Sample Policies & Procedures
- Policy Updates
- 330 Advocacy Information
- Other: _____

8. What can the NHCIW improve upon?

9. How can we help you get more involved with the NHCIW?

Additional Questions for Health Centers:

1. What actions has your health center taken to protect immigrant patients? Check all that apply.

- Attended trainings provided by CPCA and/or CaliforniaHealth+Advocates related to preparing for an encounter with immigration enforcement by adopting sample policies and procedures
- Hired staff or properly trained staff to be enforcement liaisons (handle all contact with law enforcement or immigration agents)
- Adopted elements of CPCA’s immigration model policies and procedures
- Have established the waiting room as a private space
- Have created a resource corner where patients can obtain information on immigration related policies and issues
- Trained staff on protocols and Know Your Rights information
- Gathered contact information from local ICE detention centers
- Established relationship with at least 1 immigration attorney or lawyer
- Created a response team (e.g. consisting of members of the community, attorneys, media, foreign consulates, immigrant partners and community leaders)

2. Has your health center been in direct contact with law enforcement or immigration agents?

- Yes
- No
- If yes, did you complete a siting report? Did you submit this to your state PCA?

3. Has your health center attended any of CPCA’s immigration trainings?

- i. Yes
- ii. No
- iii. If yes, did the information provided at the trainings help you prepare for an encounter with law enforcement/immigration agents? Please explain:

APPENDIX 3

NATIONAL HEALTH CENTER IMMIGRATION WORKGROUP SURVEY AND INTERVIEW FINDINGS: FALL 2018

The National Health Center Immigration Workgroup (NHCIW) was created in May 2018 in collaboration with the California Primary Care Association (CPCA), the Association of Asian Pacific Community Health Organizations (AAPCHO), and the National Association of Community Health Centers (NACHC). The purpose of the NHCIW is to provide health centers and primary care associations the opportunity to address concerns at the intersection of immigration and health, and provide information and resources on policy changes that impact the health of immigrant patients. The NHCIW has kept its member apprised of policy changes related to immigration that have an impact on health centers and/or patients, such as the proposed changes to the “public charge” rule. The NHCIW has had varied participation throughout webinars, ranging from 60 to over 400 participants at a time.

METHODS

A survey and series of interviews were conducted during the fall of 2018 to identify priorities and issues areas for the NHCIW, and to gather insights on immigration-related needs among participating organizations. Ten semi-structured interviews were conducted among primary care associations (70%), health centers (10%) and advocacy organizations (20%). All interviewees were identified via purposive sampling to get a representative sample from organizations based in different geographical areas of the United States. All individuals that had previously registered to the NHCIW (a total of 251) were invited to participate in the survey. Thirty-three NHCIW members responded to the survey. Respondents included health centers (45%), primary care associations (33%), policy and advocacy organizations (9%), primary care consortia (3%), legal aid organizations (3%), organizations that provide technical assistance to health centers (3%), and academic organizations (3%).

STRENGTHS OF THE NHCIW

Both interviewees and survey respondents were asked about aspects of the NHCIW that were working well, and what aspects had been most useful to them. Survey respondents indicated that what they had most useful were: Public Charge Advocacy Toolkit (78%), 330 advocacy information (53%), CPCA Immigration Resource Page (47%), “know your rights” information (47%), and Immigration Sample Policies and Procedures (47%). Others expressed that the webinars in general had been “exceptionally helpful”.

When interviewees were asked to articulate what the NHCIW was doing well, interviewees responded that receiving accurate information particularly from legal experts, having access to resources, and the timeliness of webinars, had been critical and extremely helpful to their work.

Additionally, the focus on health care and health centers was also discussed as being a “value add”, considering the many other coalitions and organizations engaging in similar work.

“I think having the information sharing piece is definitely vital...there are other organizations or other coalitions that are also doing work in this space... I think the information sharing that goes on, that is more specific or unique to health center organizations is definitely where there’s more value add for what the workgroup is doing.”

Recommendations:

1. **Continue to provide relevant and timely information and resources focused on health centers.** This includes enhancing and developing education materials, resources, webinars, and toolkits that have been both useful and helpful.

AREAS FOR IMPROVEMENT

Engagement and Structure

When interviewees and survey respondents were asked about areas in which the NHCIW could improve upon, the following were prominent suggestions:

- Increase participation and collaboration from participants. This includes providing an opportunity to hear from other health centers and primary care associations about current issues that are being faced, as well as to share experiences and best-practices in addressing varying issues. Participants articulated that increased dialogue would enable the NHCIW to be less reactive by being able to identify issues before they receive national attention and be better prepared to confront them.
- Create sub-workgroups (based on region or political climate) that can develop materials that are more tailored to their respective needs.
- Meet regularly and on a consistent day of the month, to give everyone the opportunity to plan ahead of time.

Recommendations:

2. **Allow space for dialogue and greater participation during calls.** Respondents expressed a desire to learn more from other health centers, PCAs, and experts from different sectors. A few participants also mentioned that the workgroup currently lacked a “workgroup identity” due to few opportunities for engagement.
3. **Create sub-workgroups.** Identify individuals working on immigrant issues at various health care centers and PCAs and invite them to participate in NHCIW sub-workgroups (based on issue areas, geographical location, or political environment for example). This was a recommendation offered by some participants to create a more inclusive environment while managing the diverse needs of its members.
4. **Create a schedule for NHCIW meetings and trainings.** Schedule calls and webinars regularly and on an established date and time (e.g. the first Tuesday of every month at 3pm), to ensure that all who would like to continue to be engaged with the NHCIW can plan accordingly. Participants mentioned that at times it was difficult to participate due to last minute scheduling.

Although the need for greater engagement was the primary area for improvement discussed by participants, many participants indicated that they were satisfied with their level engagement and did not have time or capacity to engage further, which may pose a challenge as greater participation is sought.

Messaging

Although 72% of individuals surveyed reported that they were comfortable with the messaging of the materials shared with the NHCIW, a significant 28% indicated that they were not comfortable. Reasons mentioned were:

- Materials were inappropriate for 501(c)(3) organizations and/or federal grant recipients, due to advocacy components. Although appreciation for advocacy materials was expressed, a need for materials to separate advocacy and educational resources was articulated.
- Materials were not adequate for speaking with more conservative elected officials.
- Needed simpler language that was more consumer friendly

Similarly, when asked if they were experiencing any challenges with their immigration advocacy, 45% responded that they were. The primary reasons included:

- A lack of leadership buy-in. Respondents expressed that leadership did not want them to engage in advocacy work, were fearful of getting involved in immigration issues, expressed antipathy towards immigrant issues and/or lacked a general understanding of how immigration issues relate to their work.
- Did not want to attract unwanted attention as health centers that serve immigrants.
- Are based in a conservative state and need to be careful with messaging and rhetoric used.
- Cannot engage in advocacy work as 501(c)(3) organizations and/or federal grant recipients.
- Want to avoid making families more scared, which has happened after sharing information with patients.
- Insufficient time.

Similar concerns around messaging and fear of attracting unwanted attention, were discussed during the interviews

“...there’s a lot of political tension...so trying to walk that fine line for us is hard you know, sometimes the messaging that comes out of the workgroup is a little more blue leaning, and we’re hesitant to use some of that messaging sometimes because it might be too aggressive for some of our legislators. So...just recommending that you keep that in mind, we’re not all blue states, and we’re not all as progressive as California or others may be, so it would be helpful to get more neutral messaging out sometimes.”

Similarly, when asked about what their organization’s priorities were around immigration a very significant proportion indicated that they did not have one.

Recommendations:

5. **Tailor resources and messaging to diverse stakeholders.** The NHCIW should work towards adapting its resources to meet the needs of participants living in more conservative

states. Messaging as being “blue leaning” or inadequate for more conservative states was a key issue discussed in both surveys and interviews.

6. **Clarification on for 501(c)(3) advocacy.** Separate information and advocacy materials and provide additional resources and education on the appropriate advocacy actions for 501(c)(3) organizations and/or federal grant recipients; this was highlighted as an issue or concern by many participants and their leadership.

MISSION AND PURPOSE

When interviewees were asked about what the long-term mission and purpose of the NHCIW should be, the most prominent responses were:

- Continue to keep health centers informed on issues faced by immigrant patients and how to best serve this population. Particularly because it is expected that policies that negatively affect immigrant patients will continue to be developed, while health professionals can play an important role due to their existing “credibility within the healthcare community” to influence policy in a way that others may not.
- To advocate towards removing immigration status as a barrier for primary care access, and work towards ensuring that all immigrants have access to care and coverage.
- In addition to information sharing and advocacy work, include a leadership-building focus that would allow greater buy-in from leadership, as they see skills being developed that can enter other facets of their work.

“...that is also a way to get our C-suite or our admins’ buy-in, in terms of saying that this work is not just about organizing projects about advocacy, it translates...directly to the day-to-day work that we do with our patients and our communities.”

Recommendations:

7. **Maintain a health care focus on all issues discussed and incorporate skills-based components.** This will allow participants to justify their involvement of members in the NHCIW, particularly for those whose leadership may be hesitant to engage in immigration-related issues and/or advocacy work alone.
8. **Promote a unified agenda.** The NHCIW should promote a unified agenda around increasing access to health care for all immigrants, rather than subpopulations within this category, in order to ensure that all immigrants are equally protected while respecting the political concerns of health centers and PCAs around the country. Respondents described the need to create a unified agenda to inform the NHCIW’s mission and purpose in a participatory way as important, while ensuring that no one immigrant group was highlighted or excluded.

ADDITIONAL PRIORITIES

When asked about additional immigration issues that the NHCIW should focus on, 77% of survey respondents indicated migrant workers, 74% indicated DACA, 68% indicated family separation,

and 18% indicated TPS. Additional responses included asylum seekers, citizenship and immigration-related workforce issues. Meanwhile, when interviewees were asked about priorities that the NHCIW should focus on in the future, the most prominent issues were:

- Public charge. If the proposed changes to the “public charge” rule go into effect, the NHCIW should focus on how to fill in the gaps of the safety net.
- Increasing access to health care and coverage of immigrant patients. This also includes counteracting potential disenrollment of patients through best-practices and culturally competent outreach. As well as highlighting innovative approaches for “leveraging broadly available funding streams to provide coverage for people or services”.
- Monitoring new policies and issues related to immigrant patients as they arise, and providing information and resources
- Trauma-informed Care. Interviewees discussed the need for training and for a larger workforce that can provide trauma-informed care to patients affected by the anti-immigrant rhetoric. Additionally, there is a need to address the mental health and secondary trauma that health center staff experience through their work with immigrant patients and communities.
- Family separation and health care in detention centers. Ensuring that children and individuals in detention centers are receiving the health care that they need.

Recommendations:

9. **Monitor immigration-related policies.** Continue to monitor policies that impact immigrant patients as they are developed or proposed. Participants expressed the need for the NHCIW to continue to have this role, given the likelihood that anti-immigrant policies will continue to be developed.
10. **Key priorities.** Priorities the NHCIW should focus on, based on participant feedback, include public charge (addressing chilling effects, filling safety net gaps, outreach, etc.), trauma-informed care, family separation, migrant workers, DACA and TPS.
11. **Continuous evaluation of needs and priorities.** Continue to evaluate the needs and priorities of participating individuals and organizations. Facilitated discussions and short polls can be conducted during calls and can allow everyone the opportunity to provide feedback and recommendations. The need to evaluate and monitor issues of interest, needs, and level of engagement was discussed by several participants.

CONCLUSION

Participants expressed their appreciation for the work and resources the NHCIW has provided thus far. However, the need for increased dialogue and participation from all members, as well as materials and resources tailored for organizations in diverse political climates was largely emphasized. Participants also requested that the functions and roles of the NHCIW be continuously assessed as they should evolve contingent on changing policies and politics. It is important to note that despite the articulated need for greater engagement, organizations interviewed expressed a lack of time and capacity to engage further. Additionally, many participants expressed hesitation in articulating their organization’s immigration-related priorities or stated that their organization did not have immigration-related priorities, which may pose a challenge if greater participation and involvement from members is pursued.