Center for Sharing Public Health Services

Rethinking Boundaries for Better Health

phnci

Cross-Sector Innovation Initiative Grantee Stories

- 2022 -

About the Cross-Sector Innovation Initiative

The Cross-Sector Innovation Initiative (CSII) was a three-year project led by the **Center for Sharing Public Health Services (CSPHS)** and **Public Health National Center for Innovations (PHNCI)**, divisions of the Public Health Accreditation Board (PHAB), that encourages collaboration between public health, healthcare, and social services organizations to improve outcomes in their communities and ultimately improve health equity. Robert Wood Johnson Foundation was the funding partner of CSII.

Over the course of two years, CSII grantees have developed innovative programs to foster stronger, sustainable connections within each of their respective communities across the United States. Each of the ten-grantee projects highlighted in this book were focused on the value of health equity and cross-sector collaborations. CSII projects also highlighted the necessity of developing a deeper understanding of the unique challenges and opportunities that sustainable connections represent for governmental health departments and how to best address them.

Each of the CSII grantee stories outlined in this book describe the unique characteristics of their communities, the challenge presented to each grantee, the solution each grantee developed to approach their community's challenge, and the results from implementing their solutions.

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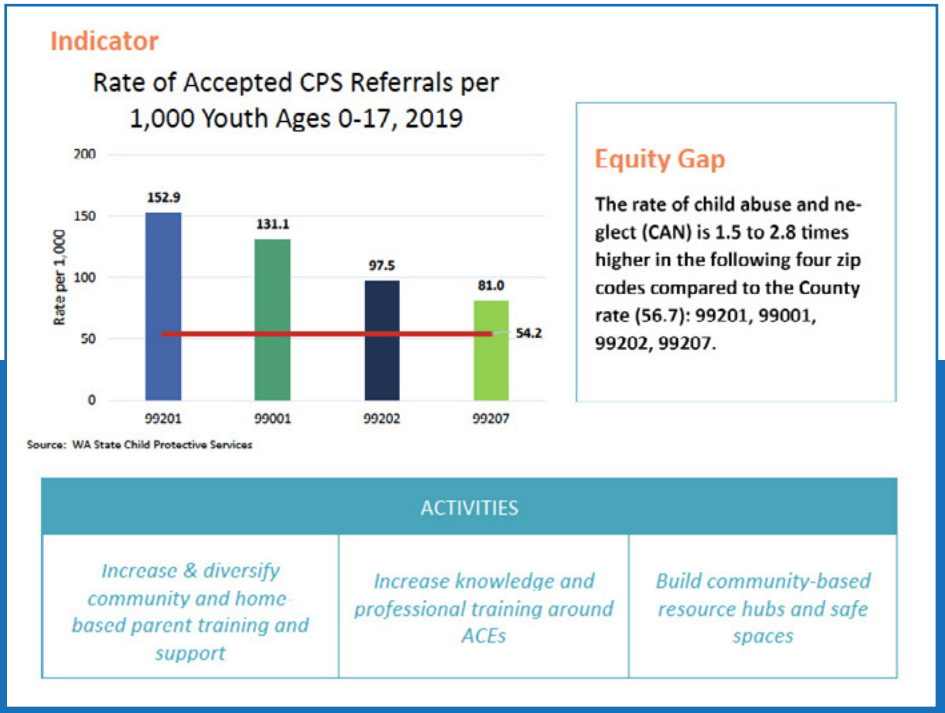
Better Health Together Collaborative

Community Description

In 2018, Spokane County was the fourth most populous county in Washington State with 507,950 individuals. According to 2017 data, Spokane County was not very racially diverse. However, many health outcomes and access to services are persistently worse among racially diverse county residents. In 2017, the median household income in Spokane County was $53,043, lower than that in Washington State ($67,106), and the United States ($57,617).

Challenge

Better Health Together (BHT) began as a task-oriented collaborative with workgroups that aimed to reduce family violence and trauma (with a focus on child abuse and neglect - see graph), increase access to affordable housing, and increase access to behavioral health treatment in Eastern Washington. When the COVID-19 pandemic hit, in-person meetings were no longer possible, and collaborative members were momentarily focused more on their



respective missions rather than the work of the collaborative. This pause gave BHT leaders the opportunity to consider how best to leverage the collective interests and resources of their large (nearly 50 organizations) and diverse membership.

Solution

BHT focused on building relationships, trust, and rapport between and among the organizations in the collaborative to provide the foundation for new and creative partnership work. They hosted a series of 7-minute long 'speed dating' sessions via Zoom, connecting participants from partner organizations with someone they had never met before. BHT members found these sessions to be very useful for building relationships and learning about each other's work.

BHT also conducted the **Wilder Collaboration Factors Inventory assessment** with the organizations every six months and used the results to guide further actions to improve collaboration among its members.

Results

- Through the 'speed dating' activity, BHT was able to create over 100 new connections between organizations.
- BHT members define the health system now to include social determinants of health and community advocates, representing a significant shift from the traditional medical model and paving the way for equity-centered work.
- BHT developed a one-year action plan to continually increase engagement and improve on lower scoring areas within the assessment. The assessment will be conducted on an annual basis, and the plan will be refreshed accordingly.

GRANTEE NAME:
Better Health Together Collaborative

Health Improvement Partnership—Cuyahoga

Community Description

Cuyahoga County, one of the largest of Ohio's 88 counties, includes the City of Cleveland and 58 suburban communities. The total population from 2017 estimates is 1.25 million, with 59% of residents identifying as White, 29% as Black, 6% as Hispanic, and 6% as other. Children younger than 18 comprise 21% of the population, and those 65 and older make up 18%.

Challenge

Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) is a consortium comprised of over 300 community agencies and 1,000 community members with a common mission to support opportunities for those who live in Cuyahoga County to be healthy. Cuyahoga county was challenged by structural racism that negatively impacted health outcomes for people of color. HIP-Cuyahoga and partners aimed to develop a plan to achieve equity at the community level as part of the health improvement consortium, rooted in the belief that "structural racism limits opportunities for some, but contributes to poor health for all."

Solution

The team used community-based system dynamics as a tool to model and develop causal loop systems maps (see example below). These maps identified key structures within the system of structural racism and identified leverage points and areas of intervention to address racial and health equity. They did this work across sectors and with grassroots community representatives.

Computer simulation models, based on the causal loop systems maps, were used to simulate impacts of various interventions to address structural racism in their county. Models were developed in areas such as systems change for racial equity, racial trauma, healing and perspective

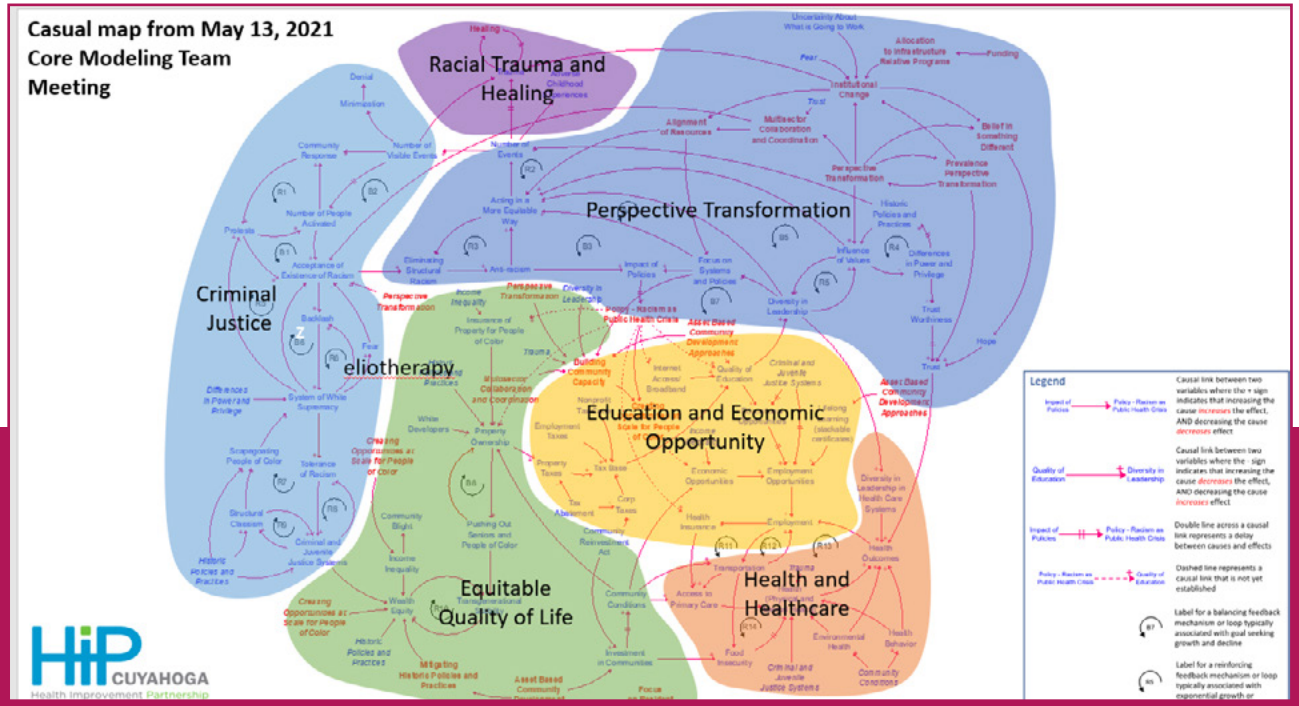
transformation, and community health worker impact on the health system.

Results

- The modelling fostered deep conversations amongst Consortium members about the impacts of structural racism, prompting a shift in approach by including interventions aimed at racial trauma, healing and perspective transformation.
- They noted external outcomes in the community including increased news coverage, inter-personal conversations, racial justice activism by community groups, and uptake of the HIP-Cuyahoga Consortium trainings and modelling work.

GRANTEE NAME:

Case Western Reserve University



Substance Use Network Project (SUN Project)

Community Description

Cabarrus County, North Carolina has an estimated population of 231,278 (2021 Census estimates) with a poverty rate of 8.0%. Nearly 70percent of Cabarrus County residents identified as White, 21.2% Black or African American, and 11.7% Hispanic or Latino.

Challenge

Stigma can be a powerful barrier for pregnant women with substance use disorders (SUDs) to seek care. Additionally, it can be difficult for them to find a provider because of the complex needs and high-risk nature of their pregnancies and obstetricians' lack of knowledge in treating SUDs. Moreover, SUDs can make it difficult for pregnant women to follow prenatal and postpartum care plans. Collectively, these factors decrease the chance that pregnant women with SUDs will deliver healthy, full-term babies. The Cabarrus County Partnership for **Children's Substance Abuse Network (SUN) Project** aimed to provide comprehensive care to increase positive birth outcomes among pregnant women with SUDs to have healthier pregnancies, deliveries, and babies.

Solution

The SUN Project took an innovative approach to developing a network of agencies and providers with the aim of coordinating the support needed by pregnant women with SUDs to access prenatal and postpartum care.

The network includes social workers, physicians, mental health providers, peer support specialists, and in some cases, probation officers. Historically these providers, specialists, and other entities work separately from one another to play their own siloed roles in supporting pregnant women with SUDs, which has led to miscommunication, mistrust, and stigmatization. Through the SUN Project and its network, pregnant women were given positive reinforcement to build trust through this support system, while working to destigmatize SUDs. An attorney assisted the SUN Project to overcome HIPAA restrictions so the network could share information with one another. The network meets regularly to ensure pregnant women get the care and support needed to keep the mother and baby healthy and safe.

Results

Over the course of the grant period, the SUN Project was able to:

- Engage approximately 30 pregnant women with SUDs.
- Establish relationships and trust amongst partners that support pregnant women with SUDs, e.g., housing, hospitals, and other social services.
- Provide education and training to obstetricians who participated in the network so that they could quickly learn how to treat SUDs in addition to the pregnancy. Despite a historical reluctance to treat pregnant women with SUDs, an increasing number of obstetricians are joining the SUN Project, increasing access to care for this population.
- Participate in advocacy efforts to extend Medicaid coverage during the post-partum period from 60 days post-partum to 1-year post-partum. This policy change would increase healthcare insurance coverage to populations that otherwise would go without it, advancing equity across sectors.

GRANTEE NAME:
Cabarrus County Partnership for Children

Equity for Moms Across Chatham (EMBRACe)

Community Description

Chatham County, North Carolina has experienced double digit growth since 2010, but as of 2020 two-thirds of the 76,285 living in Chatham County still live in rural areas. The overall racial/ethnic composition of Chatham County is 82.2% White, 12.0% African American, and 12.2% Hispanic. There are notable economic and health inequities in the county with African Americans and Hispanic/Latinos in Chatham County being two to three times more likely to live in poverty. The top 5% of earners in the county make 28 times more than the poorest 20% of households.

Challenge

Infant mortality rates in Chatham County are 2.2 times higher for Black babies (18.7) that non-Latinx While babies (7.9). The low and very low birth weight rate is also higher for Black newborns (21.4%) and Latinx newborns (11.6%) when compared with non-Latinx White newborns (9.3%). Formed in 2019, Equity for Moms and Babies Realized Across Chatham (EMBRACe Coalition) is dedicated to achieving equitable birth outcomes across the county through community-led systems

change. Their strategies address different facets of the systems that support pregnant women from the prenatal period through the postpartum period, and one of their initial efforts was to ensure that the county's new hospital maternity wing operated in a culturally competent manner.

Solution

EMBRACe originally sought to establish a Community Advisory Board comprising women with lived experience to assist with the development of culturally relevant practices in the maternity wing. However, the pandemic necessitated a pause in these plans because the in-person work to recruit board members could not be completed as planned.

During this pause, EMBRACe members realized the importance of devoting at least a year to build relationships and trust with the community and also asking the community the best way to be engaged in improving birth outcomes.

EMBRACe soon learned that the women they served wanted to be comfortable speaking truth to power, and therefore the coalition hired a local racial advocacy group to lead story circles. Story circles provided women with lived experience, the opportunity to share their stories and insights while equipping them to be powerful advocates for themselves and for systems change. These moms are driving the pace for additional developing recommendations to promote culturally competent practices in the hospital's maternity wing. The evolution of EMBRACe's approach is a stark departure from typical grant-funded efforts that place a premium on specific timelines and outcomes before a project has even begun.

Results

Over the course of their grant period, EMBRACe was able to:

- Develop a shared vision of equitable birth outcomes.
- Engage community members in designing solutions to meet their needs.
- Collaborate to create a shared governance structure.
- Earn a 100% referral rate for potentially eligible parents and kids to the Department of Social Services' WIC program.
- Foster space for women to realize their collective power.
- Engage 25 women in story circles, who now facilitate story circles across the county.
- Raise additional funding for community organizing.
- Use themes from story circles to inform a new NIH-funded hypertension in pregnancy project.

GRANTEE NAME:
Chatham County Public Health Department

Health Education Council, Serving Populations at Risk

Community Description

West Sacramento, California, in Yolo County, has an estimated population of 53,637 people (2021 Census estimates) and is ethnically diverse with 26 languages spoken at the high school. Over 85% of children in the Broderick neighborhood are eligible for free and reduced-price lunch, 15% are food insecure, and 50% receive Medicaid. Additionally, one quarter of deaths in the city are due to heart disease and stroke. Kaiser Permanente identifies the city's Broderick neighborhood as a Focus Community and residents have a heart disease rate 23% higher than the average for Yolo County.

Challenge

The West Sacramento area in California was challenged by high rates of cardiovascular disease throughout particular neighborhoods in the city. These negative health outcomes were impacted by the social determinants of health (SDOH) such as food insecurity and housing needs and were further

exasperated by the COVID-19 pandemic. **Health Education Council** (HEC) initially aimed to improve health equity and overall population health by reducing cardiovascular disease risk and morbidity, especially in highly impacted neighborhoods. The overall project goal shifted from addressing SDOH that impact cardiovascular health to addressing SDOH on a broader scale due to the pandemic's impact on low-income communities.

Solution

HEC members fast tracked coordination efforts to collectively address the pandemic's impact on low-income and prioritized

neighborhoods, including older adults and minority populations. Coordination efforts included providing four mini-grants of $500 to residents who shared ideas to address priority focus areas in a COVID-safe way. This proved to be a successful way to remain connected to the community during a time of unprecedented isolation and separation.

Results

Members garnered additional resources from other state agencies and worked seamlessly in new ways to increase access to food and COVID-19 testing and vaccines

Over the course of the grant period, HEC was able to:

- Deliver food to approximately 100 households monthly by partnering with the West Sacramento Housing Development Corporation.
- Host COVID-19 testing and vaccine clinics that resulted in increased testing and vaccination rates in low-income neighborhoods.

GRANTEE NAME:

Health Education Council, Serving Populations at Risk

Hennepin County Community Health Improvement Partnership (CHIP)

Community Description

Hennepin County, Minnesota is the most populous county in the state, with a population of 1,248,246 in 2019. The racial composition of the county is 74.4% White, 11.8% African American, 6.7% Hispanic, 6.2% Asian, 0.9% Native American, 3.4% from other races, and 3.2% from two or more races. Nearly 12% of the population lived below the poverty level in the past 12 months. In a health survey conducted in 2018, American Indian, US-born Black, Hispanic, and Southeast Asian people experienced frequent mental distress at a greater rate than White people and foreign-born Black people.

Similar disparities exist in housing: US-born Black people, American Indian people, Hispanic people, foreign-born Black people, and Southeast Asian people experience housing insecurity at a higher rate than White people.

Challenge

The Hennepin County community faces large, complex, and unique issues. In recognition that there is not a one-size-fits-all solution to addressing these unique issues, **Hennepin County Community Health Improvement Partnership** (CHIP) turned to the community to assess their needs by focusing on community-level engagement and organizational improvement to address large and complex issues, such as racism, as a public health crisis.

Solution

Because these issues were large and complex in nature, CHIP directed CSII funding to community organizations to put them in the driver seat to implement action within their own communities. These mini grants were used to identify local needs, ideas, and solutions within their neighborhoods and greater communities. Through this innovative approach to addressing community issues through funding community led initiative, CHIP provided:

- Thirty mini grants of $300-$500 each to individual county residents or small teams to develop and implement solutions for CHIP's priorities.
- Nine resident councils in low-income buildings with $1,000 each to increase social connectedness (e.g., create social spaces and host outdoor gatherings during the COVID-19 pandemic).
- Eight small organizations up to $5,000 to complete projects of their choosing that support CHIP's priorities.
- Four organizations $25,000 each to carry out year-long projects that support CHIP's priorities.

This new and innovative approach to funding significantly increased community-grown solutions to address the unique needs of particular communities. Additionally, this approach highlighted the importance of community involvement and input when planning community programs, emphasizing the need for communities to be at the forefront of planning and implementing health equity efforts that address disparities.

Results

Over the course of this grant period, CHIP was able to help kick start projects across the community, which can be viewed here, with two highlights below:

- Project Protect and Play: This project provided masks, sanitizing wipes, and small equipment (e.g., Frisbees, jump ropes, and hula hoops) to a local community comprised of East African families to encourage play among their children, which contributed to improved health, wellbeing, and overall physical, intellectual, and emotional strength.
- De-Stress with Art: This project provided art kits (supplies included crayons, paints, brushes, palettes, and canvases) to student residents at the University of Minnesota to allow them to connect safely and share their art, while promoting creativity and selfcare and establishing a sense of community while in lockdown.

GRANTEE NAME:
Hennepin County Public Health Department

The Health Improvement Collaborative of Southeastern Connecticut (HIC)

Community Description

The Health Improvement Collaborative of Southeastern Connecticut (HIC) serves approximately 151,000 people who live in nine different towns along the Connecticut shoreline. There are significant inequities in multiple domains, including income, education, housing, and employment.

Challenge

The HIC began when Ledge Light Health District and the local hospital collaborated on a community health assessment and improvement plan. The health assessment highlighted many health disparities between Black, Hispanic and White (non-Hispanic) residents in the community. Additionally, it was evident that structural racism was a contributing factor of these disparities. The collaborative aimed to address racism as a public health issue within the community. Through this work, the collaborative worked to better understand racial and health equity efforts across partner organizations and develop intentional processes and structures to outline decision-making and governance.

Solution

The collaborative utilized the **Racial Justice and Health Equity Framework** from the Boston Public Health Commission to inform their approach to population health and health equity.

- Ledge Light Health District made a commitment to address power dynamics, build trust, center community voices and stories, and lay a foundation for additional work to advance equity. The collaborative:

- Developed and launched an equity "pre-test" assessment for partner organizations.
- Created a Purposes and Processes document in lieu of formal bylaws and membership agreements, which among other things, institutionalized processes for financing and governance structures, outlined values around transparency and accountability, and included processes for decision making.
- Developed a monthly evening series to uplift community members as experts, highlight different facets of racism as a public health issue, and reach new community members. Community members who participated were compensated for sharing their expertise.

Results

- Twenty-five partner organizations completed the equity pre-test, providing valuable information about equity approaches and perspectives at the individual, organizational, and collaborative level. Many who completed the assessment were new to the collaborative.
- The Purposes and Processes document served as a tangible embodiment and application of the collaborative's values and priorities. The document shifted language and framing towards and actively centered on community voice. Furthermore, the document created new ways of working together and not being bound by the 'typical' or 'historical' ways.
- The monthly evening equity series supported increased engagement and trust with community members and grassroots organizations.

GRANTEE NAME:
Ledge Light Health District

Highrise Health Alliance

Community Description

There are approximately 5,300 people who live in Minneapolis Public Housing Authority's high-rise buildings. More than three-quarters of these residents are African American, 57% are foreign-born (Primarily from East African countries), and 83% are elderly or living with a disability.

Challenge

Many of the 5,300 residents living in buildings owned by the Minneapolis Public Housing Authority (MPHA) have multiple, complex health needs. Care coordinators, case managers, and community health workers provide many 1:1 services for this population, but they do not talk to each other – "the right hand doesn't know what the left hand is doing."

Residents were in dire need of care coordination for their medical and social service needs. A particular challenge included a strong need for medication management. Residents did not consistently:

- Take medications as prescribed (e.g., they would take the wrong dose, they would double up on a dose instead of taking one dose at different times during the day, they would skip a dose, etc.).
- Have enough of each medication.
- Discontinue a medication only at the advice of a physician (and not on their own volition).

Solution

The multi-sector **Minneapolis Highrise Health Alliance** (HHA) was established with the goal of coordinating resident services across all sectors.

HHA piloted a medication therapy management (MTM) program. The program identified older residents in public housing who took more than eight medications in a day and worked with pharmacists and physicians to review medications and make any needed adjustments to streamline. Pharmacists and physicians also worked with the residents to ensure they had a good understanding of their medication regimens.

In addition to providing the MTM program, HHA members who are employed by partner organizations are working to deliberately avoid jargon and use language that is accessible to everyone during their meetings.

Results

As a result of the community-engagement processes and community voice built into the HHA Leadership Team, the program was able to provide tailored MTM services to meet the specific needs of residents:

- One healthcare organization is providing onsite MTM to its patients who live in a specific building.
- Another healthcare organization is providing virtual MTM to its members with help from an Alliance partner organization that employs community health workers.
- Two additional members of the HHA, Minneapolis Health Department and Minneapolis Highrise Representative Council, are leveraging resident communication channels to promote MTM and help residents access the service themselves.
- The MTM program led to significant interventions among seven residents who participated.

GRANTEE NAME:
Minneapolis Health Department

Mothering Asheville

Community Description

Buncombe County, North Carolina has a total population of 231,278 (2021 Census estimates), with 88.8% identifying as White, 6.3% Black or African American, 6.4% Hispanic or LatinX, 2.3% two or more races, 1.2% Asian, 0.4% American Indian or Alaskan Native, and 0.1% Native Hawaiian or Other Pacific Islander. There are also large health disparities and racial inequities in poverty levels between Black and White residents.

Challenge

Mothering Asheville aimed to address the infant mortality rate in Asheville, North Carolina. While the total five-year infant mortality rate in Buncombe County remained relatively steady between 2007-2017, there have been persistent and increasing racial inequities that are reflected in the disparities in infant mortality and birth outcomes between Black and White infants. For example, in 2017, the five-year infant mortality inequity ratio between Black and White infants in Buncombe County was 3.8, a drastic increase from 1.6 in 2013.

Solution

As a partner of the Mothering Asheville movement, a staff member from Mountain Area Health Center (MAHEC) was tasked with co-designing strategies with women with lived experience to decrease the infant mortality rate among Black infants. The staff member met regularly with women at their apartment complex's playground, taking time to build trust and develop strong relationships before getting to the work of program design. At the behest of the women, Mothering Asheville began its "Mother to Mother" program, hiring some of the women to serve as peer mentors to provide support for pregnant Black women in a more formal setting. In addition to serving as peer mentors, some of these women went on to become trained doulas. The program staff identified a breadth of needs for participants that went beyond Mothering Asheville's mission, leading them to form a separate organization to serve pregnant Black women more comprehensively.

MAHEC supported the development of a sustainable business plan for the new

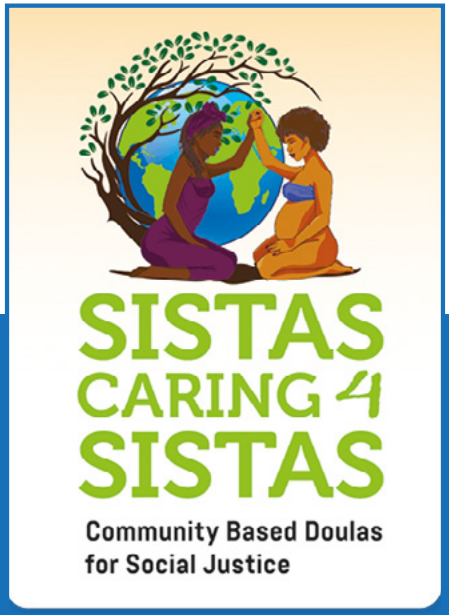
organization, as well as efforts to secure operational funding and 501©3 status. In doing so, MAHEC shifted the power of this effort to the community – a significant step to ensuring that this work is driven by authentic community voice.

Results

- **SistasCaring4Sisters (SC4S), Black Doulas for Social Justice**, was formally established as a non-profit organization in 2022.
- By contracting with SC4S, eight doulas were recruited and trained, giving MAHEC access to a total of 11 doulas.

This increase greatly helped decrease burnout rates among the original doulas and affords clients more time with their individual doula.

GRANTEE NAME:
Mountain Area Health Education Center



Live Healthy Napa County

Community Description

Napa County is a well-known wine region and tourist destination, with a population of approximately 136,000 (2021 Census estimates). The city of Napa is the largest incorporated city, with a population of just under 80,000. Much of the County is rural, with a 30,000-acre agricultural preserve that primarily supports wine grape production. The largest racial/ethnic groups in the county are non-Hispanic White (50.4%), Hispanic (35.6%), and Asian (9.1%). About one in four people in Napa County are immigrants.

Challenge

Although a large population of Napa County is Spanish speaking, leaders and members in this community whose primary or only language is Spanish often felt left out important community wide decisions. This lead to inequitable health outcomes and a lack of trust among Spanish speaking community members. **Live Healthy Napa County**/Vive Saludable Condado de Napa aimed to create inclusive spaces and increase respect and social inclusion for all members of their community. Napa County has a

large Spanish speaking community, and Live Healthy Napa County recognized the need to make sustainable and structural changes to their collaborative to ensure participation and engagement from all community members and advance health equity.

Solution

Live Healthy Napa County began embedding **human centered design** thinking into their collaborative and decision-making. Through this human-centered design lens, when more community members are trained, there has been a steady shift in how their work is approached. Live Health Napa County made intentional language justice efforts to move away from predominantly using English with a population whose first/native language is Spanish. This shift took place by creating bilingual newsletters, making key resources and publications available in English and Spanish, and hosting meetings in the language spoken by the majority of members attending any convening.

Live Well Healthy County sponsored human centered design training through the **Stanford d.school** for local community members and leaders in partner organizations, including Spanish-speaking individuals.

Results

- Empathy, a hallmark of human-centered design, helped the team consider the experiences of collaborative members and community members with diverse perspectives and experiences.
- Shifting to a bilingual collaborative supported the perspectives, skills, and contributions of Spanish-speaking community members and leaders to be more fully utilized and celebrated.
- Two d.school teams completed projects in Mental Health and Wellness and Childcare.

GRANTEE NAME:

Napa County Health and Human Services Agency, Public Health Division.