Building and sustaining a strong coalition of diverse, yet invested participants is no small challenge. We recently asked the Bridging for Health advisory panel for their tips for building an inclusive collaborative, pitfalls to avoid in building a multisector coalition, how decisions about coalition makeup can benefit health equity, and for their insights on innovative ways to finance upstream drivers of health.

**Lay a Strong Foundation**

Make sure everybody is on the same page. It sounds simple, but in practice, language and framing issues can make cross-sector collaboration challenging.

“We really need to work to understand each other’s language. How do they frame things? What’s important to them?” explains Craig Weber, founder of the Weber Consulting Group. “Framing is really important, so everyone is on the same page about what we’re trying to accomplish together, why it matters to all parties involved, and then how we work effectively to coordinate actions and address the goals we are trying to accomplish together.” Weber stresses this is critical, up-front work, especially for groups of people who have not previously worked together. “If you underinvest in that process, you always pay for it downstream,” he warns.

Synchronizing language, framing, and goals plays a key role, Weber says, in deliberately designing engagement to achieve big change.

“If people don’t see the price they’re paying for the status quo and the advantages they can gain from the changes you’re advocating,” Weber says, “They’re very unlikely to come to the table in an eager way, meaning they’re very unlikely to roll up their sleeves and do the hard work required to create change.”

**Recognize Partners’ Strengths**

One key to getting collaborative partners to meaningfully engage is playing to their strengths. “What we find is that you can have much more specific conversations with partners if they are not just sitting at the coalition table waiting for our long process to play out,” says Soma Stout, executive lead of the 100 Million Healthier Lives initiative at the Institute for Healthcare Improvement. “Instead, be able to make that more specific ask that matches the strengths and readiness of the partner to contribute to solutions that are needed to improve the well-being of a community. We find this usually leads to a better and more efficient outcome.”
In some cases a partner’s strength can be in its influence to convene.

“It is very easy to say, ‘We need to all be connected so we are going to host the party,’ rather than saying, ‘Who is best positioned to invite the residents most affected by the work that we are doing who are to become part of convening and help envision what’s possible for the future?’” says Ruth Wageman, director of stewardship at ReThink Health.

Be Inclusive

“Our tendency is to go to people who think a lot like us, because we are more comfortable with them, but we have got to break out of that,” says Vondie Woodbury, consultant and former vice president of community benefit at Trinity Health. “More often than not you will work with a coalition and it is all nonprofit folks who are in the business of doing community types of work. Yet, there are other huge pieces of the community who are absent.”

Community coalitions need to take significant steps to ensure they truly represent the community.

“Rather than trying to guess what would improve health equity, integrate people who are going to be most affected by the thing that we’re trying to improve in the design process,” explains Stout. “We really strongly encourage leaders to use codesign processes to get out of boardroom and coalition tables and to be in kitchen tables, to shift the balance of power in those conversations but more importantly to recognize that people with lived experience of a particular inequity have a wealth of experience. We’re inviting them to be the creators of the solution.”

Engaging those community members from the beginning is essential.

“The underlying stance of great partners and would-be stewards is understanding that this is about the residents of a community and that the work is not about doing something to them,” says Wageman. “It is about doing something with them and thinking right from the beginning about how residents can be driving what this is all about — what its ultimate aims are. How are our efforts going to be accountable to particularly those who are most suffering and the most vulnerable populations.”

Woodbury says that additional steps coalitions can do to go the “extra mile” to engage community members include:

- Holding open mic nights where people are during nonbusiness hours.
- If polling, oversampling communities.
- Being knowledgeable about the data and not understating the data you have.

“Growth of ownership in the process of improving health equity by people who are most affected by inequity has real health and well-being impacts for that person and the community,” says Stout.

Bridging for Health Advisory Panel

- Kathleen Adams, Ph.D., Emory University
- John Auerbach, Trust for America’s Health
- Ian Galloway, Federal Reserve Bank of San Francisco
- Jim Hester, Ph.D., Centers for Medicare & Medicaid Services
- Soma Stout, M.D., Institute for Healthcare Improvement
- Ruth Wageman, Ph.D., ReThink Health
- Craig Weber, The Weber Consulting Group
- Vondie M. Woodbury, The Woodbury Group
Sources of Money

“I think there are two pots of money to pay attention to: financing (finding an investment partner) and finding the money associated with value that’s created from the intervention itself (cost savings),” says Ian Galloway, a senior research associate at the Federal Reserve Bank of San Francisco.

In deciding to bring on a financial partner to fund a specific project, Galloway says organizations should assess two specific conditions:

- Is there an evidence-based program that you know will improve health, but you don’t have the resources available to scale it up to meet the need?
- Is there risk involved that your organization can’t take on?

“Financing can play a really key role in giving you the working capital that you need to replicate a program or grow it so that you can effect change,” says Galloway. “But sometimes you have a good sense that a program is going to work, but you don’t know for sure and you don’t have the ability to take on that risk yourself so you outsource it to a financial partner who’s willing to take that risk for you.”

The other pot of money is the money associated with value that’s created from the intervention itself. For example, Galloway cites two sources of value:

- Health care savings — By addressing social determinants associated with a particular disease (e.g., asthma), the number of people using the emergency room could be reduced, which saves money for the health care system that can be reinvested in expanding the program that tackles the social determinant.
- Societal benefit — If more kids are growing up ready to learn, that can translate into many long-term societal benefits that can be assigned a monetary value.

“That’s the business proposition — a combination of ‘Is this going to save money if we’re successful?’ and ‘What kind of value is this producing for society?’ that society will potentially be willing to pay for,” explains Galloway.

“In addressing socioeconomic determinants of health, this could be as simple as providing a pair of diabetic shoes rather than a wheelchair, or the air-conditioner for the elderly patient rather than the hospitalization. It is hard to measure the cost and impact of the avoidance and therefore harder for financiers to envision the benefits, or return on investment.”

Return on Investment

The key to getting many partners on board to pay for better population health is stating a clear value proposition of why they should care.

“I think historically we’ve been too quick to limit the value of health to the health care sector,” Galloway admits. “But we know health extends well beyond access to medical care. It extends into the community, into the home, into our schools. Making the case that improving all of those things is as important, if not more important, to health is really important, I think, in getting more people to the table and willing to participate in a larger initiative to improve health.”

Central to attracting partners is explaining the benefits of investing in upstream drivers and population health to nonhealth folks.

“We need to work on the idea that there is a return on investment to making our population healthier,” says Kathleen Adams, professor at Emory University's Rollins School of Public Health. “Whether that’s at home, or in
the workplace, or in the play place, businesses do have a lot to gain from making situations more healthful for their workers. They are more likely to be at work every day and be more productive, so there is both private- and public-sector involvement that can take place.”

Adams says it is productive to think in terms of the idea first and the financing later, keeping in mind that financing options are subject to changing policy environments.

**Moving Investments Upstream**

There is increasing recognition of the need to more effectively integrate health and social services. Experts believe this recognition is creating opportunities for a broad range of financing vehicles to be explored as a way to pay for these initiatives.

For instance, community development financial institutions and hospitals’ endowment investment pools are being used for investments in community-development projects, says Jim Hester, former acting director of population health models at the Center for Medicare and Medicaid Innovation.

Additionally, Hester says there is increasing interest in expanding the scope of accountable care organizations to include accountability for social services in models such as social health maintenance organizations or total accountable care organizations.

In order to make the investment case for these models, Hester urges collaboratives to document the impacts on more sectors and broaden the set of measures included in of data collection. Hester urges collaboratives to consider, “What is the state of well-being of the population? Is the population health initiative reducing the demands or cost for services not only in health care but also in other sectors?”

For example, Hester cites a hub-and-spoke model implemented in Vermont to curb opiate addiction. The hub of specialists is able to increase the capacity of primary care practitioners to manage opiate addiction. Extensive data collected by initiative was able to show numerous benefits, including the impact on the criminal justice system in terms of reduced incarceration for opiate-related offenses and recidivism.

Communities exploring innovative ways to finance upstream drivers of health need to pay attention to the sources of funding (financing or reinvestment of savings), as well as evidence that can inform both upstream targets as well as potential return on investment.

**About Bridging for Health**

Many national efforts are underway to encourage communities to explore novel mechanisms to fund initiatives targeting the upstream drivers of health and wellness. Bridging for Health: Improving Community Health Through Innovations in Financing, supported by the Robert Wood Johnson Foundation, takes a systemic approach to improving population health. It fosters connections among diverse stakeholders to align investments to target the upstream drivers of health that will ultimately improve population health outcomes. To accomplish this, Bridging for Health focuses on the linkages between three key areas—innovations in financing, collaboration, and health equity.

**BRIDGING FOR HEALTH**

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