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Organizational Risk in Multi-Sector Health Partnerships:
a Case Study of Oregon's Accountable Health Communities

by

Shauna Jean Nicole Petchel

A dissertation submitted in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
Health Systems and Policy

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Abstract

The literature on collective action has documented that the perception of organizational risk – both the uncertainty of potential outcomes and the meaning attached to them – is an important factor in whether and how organizations engage in cross-sector collaborations. Yet there are few examples to date that document how health and social service leaders perceive organizational risks in cross-sector health partnerships focused on social determinants of health, or how their perceptions influence organizational commitment and willingness to engage in these partnerships over time.

This research aimed to fill this gap through a mixed methods case study of health and social service organizations in four suburban and rural communities in Oregon that were engaged in the Center for Medicare and Medicaid Services' Accountable Health Communities (AHC) initiative in 2019. Initiatives such as AHC are intended to overcome the challenges of coordinating the delivery of health care and social services by implementing new processes for systematically identifying patients' unmet social needs, connecting patients with appropriate community resources, and leveraging care coordination technology to monitor these efforts over time.

Interviews and surveys were conducted with organizational leaders at primary care, public health, and dental care organizations participating in patient screening, referral and navigation activities for unmet social needs. Patient referrals data were used to identify and recruit social service organizations that had received patient referrals through AHC; these included community-based and faith-based social service agencies,

affordable housing organizations, and emergency food and shelter programs. Interviews and surveys were thematically analyzed to explore and compare how organizational leaders perceived the risks of cross-sector partnerships, and how these risks varied across organization and sector lines.

This research found that health and social service leaders described different constraints and resource dependencies and held different views on whether and how multi-sector collaboration advanced their organizational interests. Health and social service organizations operated within different sociopolitical contexts and were highly adapted to specific service populations, issues and funding streams that were narrowly defined within various federal health and human services policy. Misalignment of these categorical distinctions at the federal level created perceived risks in multi-sector collaboration at the point of service delivery due to potential noncompliance or risks of reputational harm.

Health and human service leaders described the purpose of cross-sector projects such as AHC in terms of increasing connectedness of, and interprofessional knowledge among, health and human services workers, rather than increasing the ability of their clients to access services. This research suggested the value of multi-sector collaboration through interventions such as AHC may be in increasing organizations' visibility to one another and helping organizational leaders identify partners and better advocate their interests within their community (particularly through community-level data). Achieving balance between this perceived value of collaborations and the perceived cost of new meetings or accountabilities appeared to be a delicate process, easily destabilized when

multiple collaborative efforts competed for the role of cross-sector convener in a community.

Finally, this research revealed that cross-sector networks of health and social service organizations possessed complex social dynamics, with power exercised by organizations in subtle ways such as control over community meeting agendas and community health improvement plans. Researchers are increasingly identifying the ways that health and social services work is interconnected in its delivery and its outcomes, revealing new opportunities for both sectors to influence one another or try to exercise control over shared resources. As policymakers and organizational leaders seek new ways to promote population health by aligning the design, financing and delivery of health and social services at the community level, this research suggested it may be important to monitor how power is exercised within multi-sector partnerships, recognizing that any effort that aligns organizations around shared health priorities will also direct attention away from some issues, and any effort to establish shared infrastructure for cross-sector coordination will also create new opportunities for these systems to be exploited.

Dedication

For Troy

Acknowledgments

My name is on the title page, but this work was a team effort. To the people in Oregon who participated in this research – thank you so much for being generous with your time and trusting me with your stories. I am inspired and humbled by your thoughtfulness, your perseverance in the face of wicked problems, and your commitment to the people we serve.

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Chapter One – Introduction

Achieving Systemic Action on Social Determinants of Health

Since the emergence of the field of social medicine in the mid-twentieth century, groups such as the World Health Organization have increasingly recognized the importance of factors such as housing, nutrition and violence for population health (Solar & Irwin, 2010). Research suggests that behavioral, social and environmental factors may contribute as much as 80-90% toward the health status of a population, while traditional medical and health services may represent as little as 10-20% of health determining factors (McGovern, Miller, & Hughes-Cromwick, 2014).

This evidence of the importance of social determinants of health (SDOH) has raised new debates among researchers and policymakers about the role of the health system in promoting and securing population health (Eggleston & Finkelstein, 2014). For example, the World Health Organization's Commission on Social Determinants of Health proposed that the health system holds the power to mediate or exacerbate differences in material, biological and social circumstances within the population that give rise to health disparities (see Figure 1.1) (Solar and Irwin, 2010). The goals of the "Triple Aim" – better population health, lower cost and better individual experiences of care (Berwick, Nolan, & Whittington, 2008) – also appear to be more fully realized when nations prioritize investments in a population's social rather than medical needs (Bradley et al., 2016). Yet U.S. social welfare policy has not historically been organized around these priorities and has directed a larger share of resources toward medical services while

underinvesting, relative to other developed nations, in social services (Bradley & Taylor, 2013).

Figure 1.1: World Health Organization’s Conceptual Framework of Social Determinants of Health (Solar and Irwin, 2010)

The early years of the twenty-first century brought new urgency and visibility to this issue as millions of Americans experienced financial hardship during the Great Recession (Jenkins, Brandolini, Micklewright, & Nolan, 2012) and hundreds of thousands of veterans returned home from the Iraq and Afghanistan wars with trauma-related physical, mental and substance-use conditions (Seal, Bertenthal, Miner, Sen, & Marmar, 2007; Reno, 2013). During this time, the health system was increasingly described as being trapped within a “death spiral,” of rising health care costs and lower rates of insurance coverage (Cutler & Zeckhauser, 1998; Hussey, 2007). Describing the emerging sense of crisis that the U.S. health system was not equipped to meet these challenges, Stange (2009a, p.100) wrote:

“Underlying the current healthcare failings is a critical underappreciated problem: fragmentation—focusing and acting on the parts without adequately appreciating their relation to the evolving whole. This unbalance, this brokenness, is at the root of the more obvious healthcare crises of unsustainable cost increases, poor quality, and inequality. Fragmentation is at the heart of the ineffectiveness of our increasingly frantic efforts to nurture improvement.”

Spurred in part by the passage of the Patient Protection and Affordable Care Act (2010) – both its expansion of insurance coverage to millions of previously-uninsured Americans and its mandate to reform the delivery of health care – the U.S. health system began to reorganize over the next decade with renewed attention to this issue of fragmentation and its implications for addressing the social determinants of health. Perla and Onie (2016) argued that it was difficult to conceive of a truly patient-centered health system that ignored issues of homelessness or domestic abuse, or of health care cost-containment strategies that did not account for the majority of known health determinants. Simulations of health system improvement strategies found that without broader investments in the social determinants of health, savings from health system reforms may erode or disappear after five to ten years (Homer, Milstein, Hirsch, & Fisher, 2016). While the health and social sectors were fragmented and disconnected in their strategies and service delivery systems, they were increasingly recognized to be highly interdependent in their effectiveness and outcomes (Hargunani, 2017).

The Promise of Multi-Sector Health Partnerships

Recognizing these challenges and opportunities, health system transformation advocates began to call for better identification of the key players involved in promoting population health outside the health system, and better coordination among these diverse partners to achieve better overall population health outcomes (Trujillo & Plough, 2016).

Weil (2016, p.1947) wrote, “...existing boundary lines must be crossed. Whether it is the public and private sector, the health and social sectors, or the silos that exist within the health care system, a new culture requires combined efforts that remove the barriers that each has placed around its work.”

At the national level, inter-agency coordinating councils and a new National Prevention Strategy encouraged health care, public health and social service organizations to form new partnerships that crossed traditional sector boundaries (Benjamin, 2011). Federal agencies loosened some of the regulatory restrictions in programs such as Medicaid that prevented payments across sectors to improve population health (Machledt, 2017). States took advantage of federal policy waivers to experiment with new approaches to integrating services (Spencer, Lloyd, & McGinnis, 2015). The philanthropic sector launched new initiatives to accelerate cross-sector collaboration (Trujillo & Plough, 2016) including calls for organizations to pursue “collective impact” partnerships defined by a common agenda, mutually reinforcing activities, shared measurement, a communications infrastructure and a convening “backbone” organization (Kania & Kramer, 2011).

These efforts resulted in a proliferation of new regional “multi-sector health partnerships,” that were described as “a new organizational layer across the U.S. health landscape” (Erickson et al., 2017, p.27). An environmental scan of emerging multi-sector health partnerships (MSHPs) in the United States in 2017 identified seventeen different national initiatives and more than 450 regional networks that had formed within the prior three years (see Figure 1.2) (Brodt, Kang & Rein, 2017).

Figure 1.2: Environmental Scan of MSHPs (Brodt et al., 2017)

While these initiatives varied in their designs and approaches, they shared characteristics including a focus on social determinants of health, organizational members that reflected both health and non-health care sectors, and actions to coordinate workflows and accelerate information sharing among members (Brodt, et al., 2017). For example, the BUILD Health Challenge, launched in 2015 by a consortium of foundations, health services researchers and health systems, convened 37 regional health collaboratives across the country (“About”, 2018). One such site was in a high-poverty area of east Portland, Oregon and brought together the county health department, a major health system and multiple local nonprofits to train Community Health Workers and community-based medical interpreters to support residents in navigating the health system (Thorstenson, 2015). In another example, the State of Oregon, Lane County and Multnomah County joined the Obama Administration’s Data-Driven Justice Initiative in

2016 to foster collaboration between the criminal justice system, health system and local governments to disrupt the co-occurring cycles of incarceration and hospitalization for people with mental illness and substance use disorders (Sieng, 2016).

New evidence suggested that communities that achieved cross-sector coordination among their health care, public health and social service sectors also experienced declining rates of chronic and infectious diseases (Mays, Mamaril, & Timsina, 2016). When resources were used flexibly among health and social services within an integrated system, the health care savings could exceed the new costs for social services (Sandberg et al., 2014). Describing the value of such collective impact approaches in the face of complex problems, Kania and Kramer (2013) wrote:

“The power of collective impact lies in the heightened vigilance that comes from multiple organizations looking for resources and innovations through the same lens, the rapid learning that comes from continuous feedback loops, and the immediacy of action that comes from a unified and simultaneous response among all participants.” (p.1-2)

Yet closer examination revealed that many groups that had adopted the goals and labels of this cross-sector MSHP movement struggled to achieve its intended infrastructure or process changes (much less its’ intended outcomes). A survey of more than sixty MSHPs identified common challenges, including inability to measure impact, lack of information-sharing infrastructure and lack of options for sharing costs and savings (Amarasingham, Xie, Karam, Nguyen, & Kapoor, 2018). Health systems were often represented in MSHPs by their community benefit departments rather than senior leadership, and other key partners such as payers and economic development organizations were often entirely missing (Siegel, et al., 2018). The governance models

used within MSHPs varied considerably, with some groups organized around a central convener or backbone organization and others adopting shared, decentralized governance (Brodt et al., 2017). Even within supposedly exemplary MSHPs, these governance structures were observed to be fragile and often heavily dependent upon the efforts of a one or a small number of organizations rather than a robust network of partners (Siegel, Erickson, Milstein, & Pritchard, 2018).

At the time of this research, there was also not yet much evidence that meaningful collaborative activities were taking place, or that MSHPs were succeeding in their goal of shifting organizations away from short-term, individualistic strategies toward a common agenda and shared definitions of success (Siegel, et al., 2018). Health system leaders reported skepticism that their organizations could meaningfully influence health determinants beyond the boundaries of the health system or that these impacts could be measured if they occurred (Martin, Nelson, Rakover, & Chase, 2016). Despite often serving the same populations, the health and social sectors were observed to have their own tools, strategies, funding streams and data systems (Brodt et al., 2017). Different privacy considerations across these two sectors also pointed to significant challenges for information exchange (McGraw, 2014). It was often easier for health care organizations to develop social care solutions for individual patients than to scale solutions as whole programs due to resource constraints and competing priorities among organizational stakeholders (Frazee, Lewis, Rodriguez, and Fisher, 2016).

Most MSHPs had not begun with long-term funding in place and, at the time of this study, there was no model for sustainably financing these partnerships without

external support (Cantor et al., 2015). Even when exchange of services and referral of patients across sectors was robust, the public funds that supported services within the health and social sectors remained categorically restricted; policy often prevented or forbid organizations from using their existing revenue streams to fund services that crossed sector lines (Fisher & Elnitsky, 2012). There was little evidence that even the most mature MSHPs had developed successful strategies or policy reforms to address these long-term sustainability challenges (Siegel, et al., 2018).

It was suggested that Medicaid, already serving diverse populations with substantial social service needs in all fifty states, may be the best existing policy platform from which to finance further health and social services integration (Machledt, 2017). Hester (2018) wrote that “...increased attention to population health has stimulated an increase in sources of financing that potentially provide more stable support for population health programs. In addition to funding program operations, some of these sources could support infrastructure costs and capital investments.” (p.572). States including Oregon, Massachusetts, New York and Utah had begun experimenting with the use of Medicaid demonstration waivers to support health-related nonmedical services for patients (Spencer, et al., 2015). Under Oregon’s 1115 Medicaid Waiver spanning 2012-2017, Coordinated Care Organizations had been authorized to provide certain non-medical “Health Related Services,” which included both direct provision of social supports to Medicaid-enrolled individuals, as well as “Community Benefit” activities that promoted population health in the region as a whole (“Health Related Services,” 2017).

Loosening restrictions on funds such as Medicaid had been found to be important – but not sufficient – to support the development of new workflows, as health care organizations were still challenged to devise new processes or develop new relationships with social service providers (Spencer et al., 2015). Even when reimbursements or other payment mechanisms were put in place to support population health efforts over time, the up-front cost of system changes remained a barrier to collaboration because someone must bear these up-front costs (Roman, 2015). Evaluations of Medicaid care management fees introduced in 2015 found such challenges – financial incentives were an important step, but not sufficient to drive organizational changes in the absence of implementation support (Perla & Onie, 2016). There was not much evidence to guide what should happen after unmet social needs were identified by a health service organization at the individual or community level (Amarasingham, et al., 2018). Concerns were raised by researchers and health care providers that it may not be ethical to screen patients for social risk factors when it is unknown whether there are adequate resources in the community to meet their needs, or when providers may direct patients to inappropriate resources (Garg, et al., 2016).

Perla and Onie (2016) noted that overcoming these challenges and “developing a reliable and effective social needs screening and action program would require that health service organizations view their assets—infrastructure, process, tools, and relationships—through the lens of health, not simply disease, and deploy them accordingly.” Yet this redeployment of existing health system assets to fund the creation and maintenance of MSHPs was controversial, and there was not consensus among policymakers or health

system leaders that the resources for new population health efforts should come from within the health system rather than from other sectors or through new public policy investments (Eggleston & Finkelstein, 2014; Katch and Bailey, 2020). As the health system transitioned toward value-based payments, health care organizations increasingly bore the risk of high health care costs and poor health outcomes (“Approaches to Cross-Sector Population Health Accountability,” 2018). Yet the churn in a given health care organization’s patient population over time was observed to create a disincentive to invest in geographic, rather than member-based, population health interventions whose benefits may accrue elsewhere (Amarasingham et al., 2018). Strategies that yielded savings, for example through reduced utilization of a region’s emergency department or inpatient care facilities, financially penalized some organizations even as they benefited the system as a whole (Machledt, 2017). These penalties were compounded by a prevention paradox – prevention of risk factors carried the greatest potential population health benefit in a region, but these benefits were distributed across a wide number of partners and sometimes occurred far in the future, while mitigation or treatment of risk factors presented the least benefit to the region as a whole, but the greatest and most immediate returns to individual organizations (Roman, 2015).

The introduction of Coordinated Care Organizations (CCOs) in Oregon in 2014 began to mitigate some of these externalities among health system organizations by establishing a global budget, shared incentives and regional performance indicators for all participating health care organizations in a region (Stecker, 2013). These reforms explicitly aimed to address the challenges described above in coordinating among

medical, dental and behavioral health services that were otherwise fragmented and historically siloed (McConnell, 2016). However, the dynamics described above were not yet mitigated between the health sector and other sectors such as social services or local government agencies serving the same geographic populations, because these sectors did not automatically participate in, and were not incentivized by, the agreements of a region's CCO. As well, even though CCOs were authorized to invest in non-medical services, they faced a disincentive to make these a significant portion of their expenditures as any services provided within this category were counted as administrative costs that the CCO was encouraged to minimize ("Health Related Services," 2017).

This issue – that the benefits of some population health efforts did not accrue to the same organizations that invested in or implemented them – had been called a “wrong pockets problem” that emerges across sectors (Roman, 2015) where,

“...the entity that bears the cost of implementing a practice—including an evidence-based best practice—does not receive a commensurate benefit. Because the costs outweigh the benefits for that implementing actor, projects in the public interest do not receive sufficient resources. Thus, project investment is suboptimal, and overall social welfare is—in equilibrium—suboptimal” (Roman, 2015, p.1).

Stated more bluntly, the economic benefits when a health system organization invested in population health – whether the infrastructure required to launch an MSHP, or the costs of meeting social care needs – “ended up in another pocket” such as savings to a government agency's bottom line or lower costs for a region's residents, if they were captured and counted as savings at all (Butler, 2015). The wrong pockets problem was cited as a major challenge in achieving sustained investments in social determinants of

health over time, even when resources were made available to offset new interventions (Machledt, 2017).

Given the wrong pockets disincentive for health service organizations to directly invest in population health strategies, as well as the policy barriers that fragmented revenue streams in the health and social sectors, many MSHPs were being financed through a variety of shorter-term investments and often through multiple “braided” funding streams at a time (Brodt et al., 2017), such as combinations of philanthropic or local government grants, hospital community benefit programs, community development financing, or experimental risk-sharing arrangements such as pay-for-success initiatives, shared savings agreements or wellness trusts (“Financing Regional Health Transformation,” 2018; Mikkelsen & Haar, 2015). The reliance on short-term and braided funding streams had raised concerns about the sustainability and volatility of such efforts (Amarasingham et al., 2018; Hester, 2018).

It was proposed that better alignment of the existing and more permanent funding streams and incentives for organizations operating in MSHPs could help to overcome these sustainability challenges (“Approaches to Cross-Sector Population Health Accountability,” 2018). AcademyHealth’s *Payment Reform for Population Health* initiative proposed four foundational elements of payment reform, including a trusted environment, shared data, alignment of community resources, and payment models that incentivize investments in social determinants of health (Martinez-Vidal, Kennedy, & Smith, 2017). In Oregon, increasing CCO investments in social determinants of health was named one of four explicit goals of the state’s “CCO 2.0” work plan under its 2017-

2022 Medicaid demonstration waiver (Brown, 2017). The State took steps to achieve this goal through the creation of an initiative that would direct CCOs to re-invest a portion of surplus revenues in social determinants of health beginning in 2021 (Oregon Health Policy Board, 2018). At the time of this research in early 2020, the State of Oregon had not yet issued a formal rule or guidance to CCOs to determine how to calculate their required investments in social determinants of health.

Communities for Health

Many scholars and health system leaders have called for strategic alignment of organizations operating within MSHPs, synchronizing organizational goals across sectors and developing shared visions (Cashman, 2016). AcademyHealth's Payment Reform for Population Health framework defined strategic alignment as "several components such as relationship building, common language/jargon translation, coordinated training and education, a centralized driving entity/force to create change, and most importantly, trust and willingness to share risk and rewards" ("Alignment of Clinical and Community Resources," 2017a, p.1). The Robert Wood Johnson Foundation's Culture of Health initiative similarly proposed that progress in population health improvement would come through "making health a shared value" among stakeholders in a region (Plough, 2015), while Henize et al. (2015, p. e996) outlined a roadmap for developing referral partnerships within communities for health, with a first step of "jointly defining a problem and articulating a shared vision."

One proposed approach to define clear roles and responsibilities for health and social sector organizations was called an "Accountable Community for Health"

(Mikkelsen & Haar, 2015), “health neighborhood” (Garg, Sandel, Dworkin, Kahn, & Zuckerman, 2012), or “health community” (Perla & Onie, 2016). This approach (hereafter referred to as a “community for health”) was described as building on the Primary Care Medical Home model’s core emphasis on screening and early detection of risk factors (Sia, Tonniges, Osterhus, & Taba, 2004) as well as the alignment of stakeholder incentives that characterizes Accountable Care Organizations (Cashman, 2016). Communities for health would aim to improve population health by shifting organizations’ focus away from member-based strategies (serving a select group of patients or subscribers) toward geographically-based strategies (serving all residents of a region) (Garg et al., 2012). While communities for health were a new and developing concept within the health systems literature; two definitions that had been proposed are presented below:

- “a multi-payer, multi-sector alliance of the major healthcare systems, providers, and health plans, along with public health, key community and social services organizations, schools, and other partners serving a particular geographic area. An Accountable Community for Health is responsible for improving the health of the entire community, with particular attention to achieving greater health equity among its residents” (“Report to the California Health and Human Services Agency Secretary,” 2015, p.2); and
- “an aspirational model where the Accountable Community for Health is accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients. An Accountable Community for Health supports the integration of high-quality medical care, mental and behavioral health services, and social services (governmental and non- governmental) for those in need of care. It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness.” (“Population Health Integration in the Vermont Health Care Innovation Project,” 2015, p.1).

States including California, Vermont, Massachusetts, Washington, and Minnesota had initiated projects to explore the potential of communities for health (“Report to the California Health and Human Services Agency Secretary,” 2015). While no single framework unified these efforts, there were many similarities across the working definitions adopted by states that also mirrored models of the broader MSHP movement (Kania & Kramer, 2011; Erickson, et al., 2017). Cantor, Tobey, Houstin & Greenberg (2015) identified core elements of the community for health model to include:

- a health improvement mission for a specific geographic community,
- organizational partners that span multiple sectors,
- a portfolio of health improvement strategies and related performance indicators,
- a communications infrastructure,
- financial resources, and a mechanism for pooling resources and reinvesting shared returns over time,
- a defined governance model and convening or “backbone” organization.

This community for health model was described as a “portfolio” approach, in which the backbone organization identifies unmet needs within the community, and then brokers connections among organizations who can partner to meet those needs, with the backbone organization serving as a hub for communication and coordination among the involved parties (Hester, 2018). The suggested strategies to be employed by a community for health included screening of patients in clinical settings for social risk factors and development of referral pathways between health service and social service organizations (Henize, Beck, Klein, Adams & Kahn, 2015). New screening tools were developed to support clinicians in conducting such screenings. For example, the Institute of Medicine (IOM) developed *Social and Behavioral Domains and Measures*, a list of 12 risk-factor

screenings (including factors such as financial resource strain and intimate partner violence) that they believed required minimal burden on primary care clinics and could be self-reported by patients (Adler & Stead, 2015). Some health care organizations experimented with care coordination technologies and electronic health record modifications to support information exchange for this type of social risk-factor screening and referral (Lindau et al., 2016; Hogan, et al., 2018).

Building on this approach, in 2016 The Center for Medicare and Medicaid Services announced a new \$157 million, five-year initiative to implement and test-the impact of communities for health on Medicare and Medicaid costs and patient health outcomes (Alley, Asomugha, Conway, & Sanghavi, 2016). Accountable Health Communities (AHC) was one of the largest community for health initiatives to date in the U.S., awarding grants to 32 “bridge organizations” across the country (CMS Newsroom, 2017). These bridge organizations were intended to convene regional partners to implement patient screening, referral and care navigation workflows for five social risk factors: housing instability, food insecurity, interpersonal violence, transportation and utility assistance.

The Oregon Rural Practice-Based Research Network (ORPRN) was selected as one of the 32 bridge organizations to develop communities for health spanning four rural Oregon communities: Southern Oregon (or the “Rogue Valley,” including Jackson, Josephine, and Curry counties), Central Oregon (including Crook, Deschutes, and Jefferson counties), the mid-Columbia Gorge (including Wasco and Hood River

counties) and the Yamhill Valley (i.e. Yamhill county) (see Figure 1.3) (“ORPRN E-News,” 2017).

Figure 1.3: Oregon's Accountable Health Communities

Beginning in 2019, the Oregon AHC project aimed to screen and refer up to 75,000 Medicare and Medicaid-insured Oregonians per year for the five AHC health-related social needs, and to implement referral and care plans for 3,000 identified “high risk” patients (“ORPRN E-News,” 2017). Nationally, the AHC initiative included two tracks: an “assistance” track that would implement screening, referral and navigation assistance to patients, and an “alignment” track (in which Oregon was participating) that, in addition to those activities, would encourage further “partner alignment to ensure that community services are available and responsive to the needs of the beneficiaries” (“Accountable Health Communities Fact Sheet,” 2016).

Questions About Strategic Alignment

The emphasis on aligning organizations around shared goals in communities for health was not a novel approach within multi-sector health initiatives at the time. However, envisioning this strategic alignment was apparently much easier than operationalizing it, as the proportion of evaluated MSHPs that had historically achieved their objectives may have been as low as 20% (Pattberg & Widerberg, 2016).

Summarizing a small but growing body of evaluation literature documenting unsuccessful health partnerships, Kadushin, Lindholm, Ryan, Brodsky and Saxe (2005) speculated that many organizations participating in MSHPs may fail to align around common goals due to racial and class tensions within communities; narratives about past experiences with partners; conflicts at the “interface” between organizations; and the potentially random pairing of available partners, resources and ideas at any specific time. Jean-Jacques, et al., (2016) found that very few multi-stakeholder collaborations were successful at implementing large-scale initiatives; those that were successful tended to have previously existing social networks of strong partnerships within their region. Kadushin, et al. (2005) reflected that efforts to bring everyone together around a central goal may create new problems for stakeholders, inadvertently co-opting the efforts of local organizations formed in response to specific regional problems or for specific underserved groups.

Bacchi (2009) has argued that within every proposed solution or new initiative, there is an implied problem that is socially constructed by stakeholders. If fragmentation in the health and social sector was the problem that was implied by calls for greater

organizational alignment within MSHPs and communities for health, then the high rates of failure in past MSHP efforts pointed to unanswered questions about the challenges of achieving such alignment. If diverse organizations were to be tasked with shifting their operating strategies and adopting shared goals as a larger “community” of organizations, it was not always clear what activities or goals organizations were being asked to shift *away from*, or the potential costs or risks to them of doing so. If further collaboration was to be achieved by aligning the incentives and risks across sectors, as some policy reform discussions had suggested (“Approaches to Cross-Sector Population Health Accountability,” 2018), then it must be understood how organizations were disincentivized to align their efforts, and why these disincentives made strategic alignment difficult.

Strategic Alignment as a Collective Action Dilemma

The difficulties of strategic alignment observed within MSHPs and communities for health were not unique to the health sector, and belong to a broad class of organizational problems that collectively are called social or collective action dilemmas (see Dawes, 1980; Kollock, 1998). As will be further discussed in Chapter Two, collective action dilemmas arise when actors face incentives to act in their individual interests rather than cooperatively, leading, in the aggregate, to a less than optimal outcome for the group as a whole (Wood & Gray, 1991). While acting cooperatively as a group may be understood by members of the group to lead to a better outcome overall, in a collective action dilemma, no individual group member is individually incentivized to behave this way. Acting cooperatively may be inherently risky for members of a group,

because the intentions (and sometimes the actions) of others are unclear and there is potentially little recourse if someone within the group fails (intentionally or not) to uphold their commitments or behave cooperatively in return. This risk, combined with uncertainty about the larger environment, creates a strong disincentive for organizations to take actions to strategically align their efforts.

As is discussed in Chapter Two, the concept of organizational risk extends far beyond the financial or actuarial risks that are often the focus of health services literature. Broadly, “risks” are uncertain events that vary in their probability and their impact on organizations (Williams, 2002). The meaning (positive or negative) attached to risks also varies among people; organizational leaders may perceive the potential risk or reward of a given activity differently depending upon the implications for their respective sectors (Williams, 2002). Organizational literature identifies many types and sources of organizational risk beyond financial risks, including risks to an organizations’ assets, its reputation, or its effectiveness at achieving its goals (including Williamson (1973), DiMaggio & Powell (1983), Milliken (1987), Sandman (1989).

Contemporary organizational theories paint organizational risk avoidance in partnerships and collective action as largely adaptive rather than deliberately competitive (see Lawrence & Lorsch (1967), Pfeffer & Salancik (1978), Williamson (2002), Perrow (2014)). From these perspectives, the health and social service sectors may be fragmented and misaligned in their strategic orientations (Biroscak et al., 2014) for the same reasons they are resilient: because they have adapted over time to the incentives and pressures within their respective sectors. While these organizational adaptations may be helpful for

fulfilling each sector's individual purpose, these adaptations can become points of conflict when attempting to work across sector boundaries (Feiock, 2013). These differences in adaptations also mean that organizations are vulnerable (or alternately, resilient) in different ways when they experiment with new approaches to their work or when they adopt new goals (Williamson, 2002). For example, effectiveness can be measured at both the organizational and group level, and improvement or attainment of goals as a group may actually manifest as lowered performance or effectiveness at the level of a single organization, representing a danger to those organizations whose performance is monitored or reported individually (Stange & Ferrer, 2009b). In fact, evidence suggests that the changes in professional values, resource flows and organizational processes required for major systems change to occur should be expected to initially result in a decline in both organizational and group performance (Hovmand & Gillespie, 2010). Yet some sectors (particularly the social sector) have adapted to be heavily reliant on community support that is contingent on perceived effectiveness (Scott & Meyer, 1991).

Risk exposure can also be conceptualized as a property of whole systems (rather than of individuals or organizations), with "shocks" flowing through a network of connected organizations following changes in policy or resource streams (Summer, 2013). Organizations can be differently impacted by shocks depending upon their degree and type of connectedness to other organizations, and the degree to which they are exposed to (or shielded from) a particular type of risk (Galán, Latek, Rizi & Perc, 2011). This variation among organizations, their interdependencies and vulnerabilities, is

described as “structural complexity” of systems that increases as the number of partners and links among them increase (Williams, 2002). Risk and structural complexity have been described as two basic elements that make the behavior of organizational systems difficult to understand, predict or change (Williams, 2002).

In summary, cooperation across diverse groups of organizations appeared necessary if the health system were to achieve its goal of addressing social determinants of health, but efforts to strategically align organizations in multi-sector health partnerships around central goals had often failed (Pattberg & Widerberg, 2016). It was not clear whether efforts to promote the development of “communities for health” such as cross-sector screening and referral networks would encounter similar challenges despite the significant resources that were being devoted to these efforts. While research had identified many operational challenges that emerge within MSHPs (Siegel et al., 2018), it was not clear how perceived risks – both the uncertainty inherent in working with others, as well as the risk that can arise when partners possess different vulnerabilities to policy or systems change – may influence organizational behavior as these groups attempted to become more aligned in their goals, strategies or workflows.

Problem Statement

At the time of this research, efforts to incentivize health and social sectors to strategically align in multi-sector partnerships did not yet reflect a well-developed understanding of the perceived organizational risks of such alignment. If barriers to strategic alignment arise because organizations are differently adapted to the risks and rewards of their specific sectors, and act to avoid unnecessary risk, then it was necessary

to understand how organizations may perceive new risks when entering into a community for health, in adopting newly aligned goals and processes, or in reporting the outcomes of such efforts to funders.

The negotiation and sharing of risks and rewards that arise within partnerships was also an important and unexplored element of MSHP formation and sustainability over time. Emerging evidence at the time suggested that few MSHPs had explicit risk-sharing arrangements (Amarasingham et al., 2018) despite the fact that the sharing of financial risk was increasingly an explicit goal of communities for health and related discussions of alternative payment models (“Approaches to Cross-Sector Population Health Accountability,” 2018). For example, discussions about the alignment of incentives and funding streams across sectors had identified that financial risk could be transferred both vertically (e.g. between funders and service providers, often via contracts or financial agreements) and laterally (through externalities created between organizations serving the same populations, whether or not they have formal business relationships) in communities for health (Discern Health, 2018). These issues had direct implications for the design and implementation of future communities for health and other MSHP efforts.

Brodt et al. (2017) noted that while there had been significant attention to population health improvement over the past decade, these discussions were largely focused on policy changes and payment reforms targeting the health system rather than social services or public health sectors. The literature on communities for health had also reflected this orientation and was largely written for, and from the perspective of, health

systems (see Mikkelsen & Haar, 2015; Cantor et al., 2015; Cramer et al., 2016; Amarasingham, et al., 2018; “Approaches to Cross-Sector Population Health Accountability,” 2018).

Yet systems thinking literature suggests that systems can be perceived from multiple perspectives, and the positionality of “the perceiver” could itself be an important factor in what was observed about a complex system (Lendaris, 1986). Organizational risk aversion is known to vary across sectors (Chen & Bozeman, 2012). The risks and rewards of strategic alignment may be perceived differently depending upon the organizational or sectoral position one viewed them from. The Rippel Foundation’s ReThink Health initiative (“Financing Regional Health Transformation,” 2018) summarized this challenge well in their discussion of health care payment reform:

“...there is far more to consider than merely identifying or mixing together the right funding mechanisms... For it is decision makers’ values, mental models, and morals that ultimately shape how funding flows over time. Particular individuals and institutions will have either a narrow view of their own self-interests...or they may have a more expansive view.” (“Financing Regional Health Transformation,” 2018)

Research Question and Aims

This study explored the following question: “How are the organizational risks of strategic alignment perceived by health and social service leaders within communities for health?” In addressing this question, the study pursued the following four aims:

1. characterize the risks of strategic alignment that are perceived by partners in communities for health, as well as the perceived causes and sources of those risks;
2. compare the similarities and differences in how various stakeholders perceive organizational risks of strategic alignment;

3. explore how perceived risks shape negotiations and act as incentives (or disincentives) for organizations to strategically align; and
4. discuss the implications of these perceptions for policy or systems changes to incentivize organizational alignment within communities for health.

Purpose and Significance

The purpose of this study was to provide insights into the perceived organizational risks of strategic alignment within multi-sector health partnerships, using Oregon's four Accountable Health Communities regions as case studies. The literature on multi-sector health partnerships while robust, has been described as reflecting an implicit ideology that particularization and narrowly defined organizational missions are problematic, while unified, coordinated approaches are preferable (Halley, 1997). Selsky & Parker (2005) noted that a critical perspective on partnerships – one that does not begin from an assumption that partnerships are perceived as universally beneficial or preferable for all participants – was lacking in the literature. They wrote “There is little attention paid to the underlying institutional dynamics, including power, that set the stage for the way social issues are defined and worked on... [Cross sector social partnerships] have a political dimension that is under-researched” (p. 867, Selsky & Parker, 2005). Kadushin et al. (2005, p.269) similarly noted that “building coalitions requires a complex social technology that is not well understood. The concept of community must be understood in practical rather than hortatory terms.”

Understanding these political and technological dimensions of communities for health was newly urgent in light of the recent focus at the time of this research on incentivizing partnership formation through payment models and alignment of risks across sectors (“Approaches to Cross-Sector Population Health Accountability,” 2018).

Many options for incentivizing cross-sector collaboration were being debated (“Elements That Support Payment Reform for Population Health,” 2017b). Lack of understanding of the leverage points that could further incentivize communities for health through policy or systems change, or the possibility that these incentives might operate differently across sectors, increased the danger of unintended consequences through experimental approaches (Meadows, 1999). Lack of understanding of the perceived organizational risks also limited researchers’ and policymakers’ abilities to identify factors that might cause a community for health to dissolve, or an organization to exit a collaborative effort after joining. Finally, the lack of critical social perspective reflected in the community for health literature had left unexplored questions about what may be lost when organizations are encouraged to align around shared goals. Exploring these issues was at the core of this proposed research.

Case Selection Rationale: Why Oregon?

A case study of Oregon’s AHC project had the potential to generate valuable insights for a wide audience of stakeholders that engaged in cross-sector efforts (see Chapter Three for a further discussion of the rationale for this case selection). The willingness of Oregon’s AHC bridge organization, ORPRN, to participate in this project, and the project’s proximity to the OHSU-PSU School of Public Health, also made Oregon an ideal and accessible site in which to conduct this research. This research had potential to inform state policy conversations that were underway at the time, as the Oregon Health Authority and Oregon Health Policy Board had recently established several workgroups and committees to accelerate health system action on social

determinants of health, and the state intended to require that CCOs allocate a portion of their future revenues toward non-medical “health related services” in the coming years (“CCO 2.0 Work Plan,” 2018).

In addition to providing insights from the Oregon AHC project, this study was intended to contribute to the scholarly literature translating organizational theories of collective action to a health systems context. This research explored the utility of one such framework of collective action (Weber, Kopelman & Messick, 2004) in the specific context of communities for health. This research provided insights that may be useful for organizational risk assessments, and pointed to opportunities for future research to test and clarify the actual (rather than perceived) organizational risks of operating as a community for health. Over time, these contributions to the literature on communities for health could reduce the inherent uncertainty in adopting MSHP approaches to population health improvement.

Conclusion

At the time of this research, communities for health were a new strategy for addressing social determinants of health by aligning health and social service organizations within new cross-sector screening and referral networks. As described in this chapter, organizational theories suggested that uncertainty about organizational partners and perceived risks of organizational strategic alignment may be important and underexplored factors that could hinder formation and sustainability of these approaches to population health improvement. How perceptions of risk might vary among diverse groups of organizational stakeholders was not well understood. Given the attention and

resources that policymakers and health system leaders were devoting to accelerating formation of multi-sector health partnerships, as well as questions about how to sustainably finance these partnerships over time, better understanding of the factors that support or undermine organizational alignment in these partnerships was needed. These issues were explored through this case study of Oregon's Accountable Health Communities.

Chapter Two – Literature Review

Overview

This chapter begins with an overview of the historical and political context for communities for health, including the evolution of fragmented health and social protections provided by federal policy over the past century; the policy vehicles through which these protections have been created and implemented; past efforts to overcome policy fragmentation through service integration; and the social construction (Schneider & Ingram, 1993) of these welfare policies, their target populations and the sectors through which they are provided.

The assumptions underlying this research proposal also derived from certain organizational and systems theories of collective action and can be explored from multiple theoretical, epistemological and disciplinary approaches (Wood & Gray, 1991; Selsky & Parker, 2005); these are explained in this chapter in the context of relevant and supporting literature. The chapter concludes with a discussion of the implications of these theories for perceived organizational risk in communities for health. The concepts of organizational and sector differentiation, organizational risk avoidance and collective action dilemmas are linked to existing research on MSHPs and communities for health, to demonstrate that these dynamics appeared to be at play and thus were worthy of further exploration.

The Historical and Policy Context for Communities for Health

The recognition of socioeconomic status as a dimension of health has emerged over several centuries, evolving from early and simple observations of the links between poverty and health to the recent surge in research exploring mechanisms and pathways by which factors such as income and stress influence health status (Szreter, 2003; Adler & Stewart, 2010). The earliest developments within the field of social medicine explored the apparent links between individual behaviors and health status, such as Morris, Heady, Raffle, Roberts, and Parks' (1953) ground-breaking research on the links between physical activity and cardiovascular disease.

Figure 2.1: Contributions of Various Domains (McGinnis, et al., 2002)

Over the past several decades, researchers and policymakers have acknowledged the role of the environment, and in particular the “built” environment of communities, in constructing human health behaviors as well as health disparities (Geronimus, 2000; “Healthy People 2010,” 2000; “Closing the Gap in a Generation,” 2008). With the

emergence of the field of epigenetics and developmental origins of disease (Messer, Boone-Heinonen, Mponwane, Wallack & Thornburg, 2015), frameworks of health determinants now also include the complex interactions among health determinants and health behaviors over multi-generational time frames (Hertzman & Power, 2003; Gluckman, Hanson, Morton & Pinal, 2005). McGinnis, Williams-Russo, & Knickman (2002) organized the various known health determinants into five domains (see Figure 2.1) and attributed more than half of the risk of disease and early death to social factors such as housing, social isolation and exposure to violence, and behavioral factors including nutrition and substance abuse. Summarizing this comprehensive view of health determinants, El-Sayed & Galea (2017, p.3) wrote:

“...the health of populations in the present is produced by influences across generations, combining forces that extend from the pre-, peri- and post-natal period through to adulthood, that include behaviors of individuals, characteristics of their social networks, features of their neighborhood physical and social environments, municipal policies, and overriding national forces including but certainly not limited to politics, laws and policies... This centrally reinforces that what matters for population health is the product of a very complex system.”

While the field of population health research has embraced this holistic understanding of health determinants as a complex system, policymakers have struggled to adapt to this more complex view of population health improvement and its implications for policy and delivery systems (Fink, El-Sayed, & Galea, 2017). In the United States, approaches to the promotion of population health reflect a high level of fragmentation, with numerous distinct sectors and agencies each devoted to influencing population health determinants within a single domain (Stange, 2009a). At the federal level alone, nearly every agency has overseen at least one distinct and independently

operated program with a health-specific objective (for examples, see Table 2.1). Many of these population health improvement efforts have been implemented through partnerships between federal agencies and states, local governments and nonprofit organizations (Lushniak, Alley, Ulin, and Graffunder, 2015).

Table 2.1 Federal Agencies Involved in Population Health Improvement

U.S. Department of Health and Human Services	Population-specific health insurance programs and health care delivery systems covering millions of Americans children, seniors and people with low incomes (“CMS’ Program History,” 2017).
U.S. Department of Defense	Population-specific health insurance programs and health care delivery systems covering active-duty military members and veterans (“About the Military Health System,” 2018).
U.S. Department of Agriculture	Emergency food assistance and food service programs such as school meals (“About FNS,” 2017); publication of the Dietary Guidelines for Americans, pregnancy and breastfeeding education initiatives (“About CNPP,” 2018).
U.S. Department of Education	Youth substance use prevention, violence prevention, and behavioral health programs in many of the same institutional settings in which the USDA oversees nutrition services (“Office of Safe and Healthy Students Programs,” 2017).
U.S. Department of Housing and Urban Development	Housing and homelessness prevention programs; programs to abate housing-related health hazards such as lead, mold and pest issues; programs for the construction and insurance of hospitals, nursing care, and assisted-living facilities (“Programs of HUD,” 2017).
U.S. Department of Justice	Violence prevention programs, including sexual assault, dating violence, domestic violence and stalking (“Office of Violence Against Women,” 2017); prevention of elder abuse, neglect and abandonment (including by caregivers and health care providers) (“About the Elder Justice Initiative,” n.d.).
U.S. Federal Transit Authority	Health care-related transportation assistance to states and communities, as well as programs focused on reducing social isolation in homebound and rural populations (“Initiatives – Rides to Wellness,” 2017).

These diverse approaches to population health improvement demonstrate that while federal agencies and their partners in state and local government and the private sector have developed detailed responses to individual health determinants, the fragmented nature of these individualized strategies has been a barrier to holistically addressing health determinants (Stange, 2009b). At the local level where service delivery

systems are built and where care is provided, differences in target populations and eligibility criteria, incompatible payment structures, disconnected timelines for disbursement of grant funds, and different rules regarding program administration and reporting have prevented the re-integration of population health strategies for the care of a single patient even when doing so would be consistent with the goals of the various involved stakeholders and programs (Fisher & Elnitsky, 2012).

The Historical Context for Health Policy Fragmentation

The patchwork of U.S. social welfare programs, policies and target populations has evolved substantially over the past two centuries. While the responsibility for promotion of social welfare is decentralized across a complex array of federal, state, local, public and private actors, this has not always been the case, and in fact there have been periods such as the late nineteenth century when the direct provision of health and social services was a major function of the federal government (Skocpol, 1995). There are documented references to coordinating the delivery of public health and social services as early as Civil War times, when charities were established to meet the needs of war veterans and victims, emancipated slaves, new immigrants, those displaced by industrialization and, eventually, in response to the Great Depression (Hasset and Austin, 1997). The role of the state expanded greatly during the Great Depression – most significantly with the Social Security Act of 1935 – and peaked with President Franklin Roosevelt’s New Deal policies, when public backlash emerged, and the onset of World War II spurred dramatic changes in the economic and social support needs of the population (Hasset and Austin, 1997).

The period immediately following World War II has been described as launching a new growth phase for the U.S. health and social sectors (Stange, Ferrer & Miller, 2009). Federal human service programs targeting specific sub-populations such as veterans, children or seniors rapidly expanded in the 1960s, which was also the period when the first large-scale efforts were implemented to “integrate” fragmented programs (Hassett and Austin, 1997). Roehrich and Caldwell (2012) described a movement toward “service bundling” that initially emerged in the 1960s in corporate America as a response to perceived fragmentation and complexity in services and products, and was later taken up by governments.

In the midst of the Civil Rights movement, the Model Cities program of the mid-1960s was the Johnson administration’s attempt to overcome a perception that organizations working on social problems were “too entrenched in traditional ways of doing things; in addition, their actions were not coordinated, even though the problems demanded coordinated attack” (Perrow, 2014, p206). The term “medical home” – first introduced in 1967 by the American Academy of Pediatrics in the context of centralizing patient medical records – was later invoked in 1974 as a larger response to health services fragmentation in a policy document titled “Fragmentation of Health Care Services for Children” (Sia, Tonniges, Osterhus & Taba, 2004). The Great Society policy initiatives of this era also contained a new explicit goal of fostering civic engagement, and a requirement for “maximum feasible participation” from the community in the local implementation of many social welfare policies (Stone, 2008).

By the 1970s the Chicago School of Economics, reacting to the Johnson administration's Great Society initiatives, began to assert a strong voice in political science circles, with a focus on marketization of public programs (Stone, 2008). Hacker (2004) observed that despite apparent stability and entrenchment of key social welfare policies such as the Social Security Act, beginning in the 1970s, opponents found ways to undermine these programs through "policy drift" (deliberately neglecting to adapt programs as new needs emerged so their effectiveness eroded over time), "layering" (creating new policies that undermined existing ones without explicitly attacking them), and "conversion" (the subversion of a program's implementation so that its effect was different than intended). The 1972 federal Allied Services Act intended to create interagency program links at the local and state level (Hassett & Austin, 1997).

However, the Nixon administration's Services Integration Targets of Opportunity (SITO) initiative was discontinued by the mid 1970s (Hassett & Austin, 1997) and Community Development Block Grants (CDBGs) were introduced in 1974 to replace post-war public health and social programs. Policymakers and evaluators cited lack of progress and understanding of local communities; that it took too long to build integrated systems that met everyone's demands; that integration efforts did not meet expectations for cost savings; that front-line staff were resistant to top-down federal approaches; and that there was a lack of evidence that the partnerships had met their goals (Hassett & Austin, 1997). Funding model changes such as block grants were cited as a solution to fragmented activities and resource streams during the Ford administration; these policy

shifts also precipitated dramatic cuts in federal social services funding in subsequent decades (Wright, Farris-Berg and Becker, 2016).

The trend toward decentralizing public health and social welfare services gained momentum in the 1980s, with federal policymakers pushing control to state and local governments (Lasker, Weiss & Miller, 2001). Charles Murray's notion that "help is harmful" in his provocative book, *Losing Ground* (1984) paved the way for a network of conservative think tanks, foundations and academic programs collectively arguing that government was incapable of improving health and social wellbeing through provision of services (Stone, 2008). The "New Public Management" approach to public administration emerged, granting control of the design and implementation of health and social service functions to community-based organizations and local governments in exchange for guarantees of performance and accountability to the state (Page, 2005).

This shift toward local governance paralleled rising dissatisfaction with, and complexity within, the delivery of human services in the public and private sectors and is credited with driving the emergence of new performance management models such as Total Quality Management and Continuous Quality Improvement (Selber & Austin, 1997). In this way, the shift toward decentralization and local oversight as a solution to inefficiency may have ironically further contributed to the perceived "fragmentation" of responses and the increasing calls for better coordination (Lasker, et al., 2001). During the 1980s and subsequent decades there was a proliferation of new multi-sector forms of action and multi-organizational groups (Selsky, et al., 2005), which were increasingly

mandated as a requirement for public and private funding of local health programs (Lasker, et al., 2001).

Many government-led integration projects begun in the 1960s and 1970s continued as informal local collaboratives after the federal government withdrew its support (Hassett & Austin, 1997). Early evaluations of these locally led interventions showed the importance of community engagement in intervention design; this gave rise to an era of “bottom-up” service integration focused on more narrowly defined, local projects (Hassett & Austin, 1997). The concept of organizational “boundarylessness” also emerged in the late 1980s as a movement within corporate America (Halley, 1997), and new technologies also began to emerge that made different forms of collaboration possible (Hassett & Austin, 1997). A second wave of service integration initiatives in the late 1980s and 1990s, spurred by both government and private investment, focused on partnerships and networks themselves as an outcome of interest (Roussos & Fawcett, 2000).

Reflecting on these dramatic shifts in the health and social policy landscape by the close of the twentieth century, Hassett and Austin (1997) proposed that the remaining challenges in the “new era” of service integration included the need for realistic expectations, clear objectives, and community buy-in. They noted that conflicting visions and motivations for reform were a problem because these visions and motivations appeared to differ significantly across sectors and across organizational levels; for example, front-line workers saw integration as a way to provide more comprehensive services, while managers saw it as a way to be more efficient (Hassett & Austin, 1997).

Health and Social Services Integration in the Modern Era

The first decade of the twenty-first century brought the onset of a global recession, the emergence of new disruptive technologies and digital communication capabilities, as well as changes in population demographics that had major consequences for the health and social sectors (Brodt, Kang & Rein, 2017). The modern era of health reform is attributed largely to the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, but there were preceding developments that may have mattered as much, if not more, for current efforts to coordinate the delivery of health and social services (Brodt, et al., 2017). For example, the concept of Accountable Care Organizations first appeared in the literature in 2007 (Fisher, Staiger, Bynum & Gottlieb, 2007), and in 2008 the IRS changed its reporting requirements for nonprofit hospitals' mandatory "community benefit" activities, adding new informational reporting requirements for a hospital's "community building" efforts (including investments in housing, violence prevention, economic development and other population health priorities) (Bakken, Kindig & Bouffard, 2014). The HITECH act of 2009, part of the American Recovery and Reinvestment Act during the Great Recession, also accelerated uptake of electronic health records by health care providers and encouraged evaluation and sharing of data across agencies and sectors that had previously been impossible (Brodt, et al., 2017).

While the ACA did not compel cross-sector coordination (Brodt et al., 2017), it did create the National Prevention Council to coordinate across 17 federal agencies under the U.S. Surgeon General; the council launched the National Prevention Strategy in 2011

that called for moving beyond a conception of health based on the absence of disease and toward one based on prevention and wellness (Benjamin, 2011). One of its stated goals was “aligning policies and programs at the national, state, tribal, local, and territorial levels [to] help ensure that actions are synergistic and complementary. When all sectors are working toward common prevention priorities, improvements in health can be amplified” (Benjamin, 2011, p.8). The National Prevention Strategy included a strong focus on cross-agency collaboration, launching several inter-agency initiatives such as the Partnership for Sustainable Communities to align housing, transportation, and environmental investments (Lushniak, et al., 2014). The ACA also directed the U.S. Department of Health and Human Services to develop recommendations on data sharing and uptake of electronic application and enrollment processes across federal and state health and human service programs (“Health IT Legislation,” 2016).

The ACA generated significant momentum toward community-based population health improvement, though these efforts largely targeted health service providers rather than social service organizations or local public health agencies (Brodt et al., 2017). The ACA created the Center for Medicare and Medicaid Innovation (CMMI) to test large-scale health care delivery system reforms and alternative payment models and enabled the first formal payments to support Accountable Care Organizations (Hester, 2018). While the concept of population health was not new, the field of public health had traditionally described populations as groups living within a defined geographic area, while the Affordable Care Act used the term “population” to describe groups of patients within a health system or even an individual clinic (Cashman, 2016). The resulting

disagreements about the proper meaning of “population health” created new debates about whether Accountable Care Organizations (ACOs), one of the signature transformation initiatives within the ACA, should be accountable for the health of their members or for the health of all who lived within their geographic area (Cashman, 2016).

Additionally, to the extent that ACOs were going “into the community” to improve population health beyond their membership base, they were largely doing so by expanding medical services (Cashman, 2016). In 2013, Bradley and Taylor published *The American Healthcare Paradox*, in which they argued that the U.S. health system was unique primarily in how it allocated its resources, devoting an unusually large share to medical and health care services while underinvesting in social services such as housing, nutrition and violence prevention. Responding to suggestions that the U.S. health system was guilty of spending too much on medical care while achieving poor population health outcomes, they wrote, “Taking both health care and social service spending into account, the United States spends a fairly average sum compared with its peer countries and, we argue, has fairly average health outcomes as a result” (Bradley and Taylor, 2013, p. 182). Bradley, et al. (2016) later expanded this work to the state level, demonstrating the same relationship between higher spending on social services and better population health outcomes on a range of measures, including asthma, adult obesity, heart disease, diabetes and cancer.

In 2012, Oregon received a federal 1115 Medicaid demonstration waiver from the Center for Medicare & Medicaid Services, allowing the state to pay its new Coordinated Care Organizations a “global” budget that could be used toward flexible services not

covered under traditional state Medicaid plans, including shelter, food, and transportation assistance if these needs were identified by a primary care provider and incorporated into a patient's care plan (Spencer, Lloyd & McGinnis, 2015). That same year, CMS' Center for Medicare and Medicaid Innovation created the federal State Innovation Model (SIM) initiative, which funded some of the first state-based experiments in multi-sector health partnerships and communities for health (Hester, 2018). In 2013, California received a SIM Design Grant and by 2014 issued the California Health Care Innovation Plan that included an initiative to develop the state's first Accountable Communities for Health pilot projects (Cantor, et al., 2015). Washington state similarly piloted two SIM grant-funded Accountable Communities of Health in 2014; this was followed by an 1115 Medicaid demonstration waiver from CMS that paved the way in 2015 for ACH demonstration projects in each of the state's nine regional service areas (Heider, Kniffin & Rosenthal, 2016). Yet an environmental scan during this period revealed no instances where a group had yet achieved all of the envisioned elements of the community for health model (Mikkelsen & Haar, 2015).

In 2015, CMS provided further guidance to states on how to design flexible community-based services, specifically looking to build bridges from health care to housing organizations (Spencer, et al., 2015). By 2016, the U.S. Department of Health and Human Services updated Medicaid managed care rules to make it easier for health care providers to work on non-medical determinants of health, building on prior efforts to link health care with social determinants through Home- and Community-Based Services (HCBS) and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

programs (Machledt, 2017). In 2016, The Robert Wood Johnson Foundation (RWJF) launched a new partnership with The Nonprofit Finance Fund to conduct case studies of MSHPs in order to build a foundation for financial best practices (McKenna, 2017). RWJF also partnered with AcademyHealth to explore new payment models via the Payment Reform for Population Health initiative (Martinez-Vidal and Kennedy, 2016). Roughly one-third of US health care payments (both public and private) had transitioned to alternative payment models by 2016, including value-based payments that provided new opportunities to fund population health initiatives targeting non-medical needs (“Measuring Progress,” 2016).

This evolution of the health care payment landscape reflected a new emerging paradigm where public funding to support health improvement could target investments in whole communities, rather than focusing on individual patients. Yet some researchers have observed that the public-private partnerships that have been increasingly relied upon by policymakers to achieve their population health improvement goals (in lieu of direct governmental provision of social services) in recent years have also transferred risks and startup costs to the private and nonprofit sectors in exchange for the promise of apparently stable revenues (Roehrich and Caldwell, 2012). The majority of social services are provided by small, locally-oriented and locally-governed nonprofit agencies; researchers have observed that these organizations have increasingly borne the risks and costs of building infrastructures to demonstrate their performance and be accountable to funders, including both credentialing and licensing, as well as the cost of new infrastructure to monitor outputs (Benjamin, 2008; Never and de Leon, 2017). These

organizations simultaneously faced tremendous pressure to maintain lean operations in their provision of services, even as they were expected to also develop or retain enduring and meaningful relationships with their cross-sector partners and the communities they served.

The resulting “liability of smallness” for these agencies meant that they achieved little return on mandated investments in accountability infrastructure, and in many cases were harmed by them during macroeconomic downturns when they experienced both increasing demand for their services and decreasing support from their government funders (Never and de Leon, 2017). The fragility, geographic variability and inadequate capacity of these organizations has been cited as a reason for caution as health service organizations aim to build new community referral connections with social service organizations (Garg, Sheldrick & Dworkin, 2018).

Identification of unmet social needs through clinical screening has also not always yielded actual benefits for patients. Researchers have noted that the screening tools being advocated for use in healthcare settings by initiatives such as Accountable Health Communities were likely to result in both false-positive and false-negative identification of some patients with unmet social needs, and that these mis-identifications could erode provider-patient relationships and waste scarce resources for care coordination (Garg, Sheldrick & Dworkin, 2018). Further, the authors argued that having unmet social needs did not necessarily mean a given patient or family desired intervention from their health care provider (Garg, Sheldrick & Dworkin, 2018). They argued that particularly in care settings that served a high proportion of socially at-risk patients, screening and referral of

individual patients may be less effective than universal approaches targeting all patients or asking patients to self-identify when they would like assistance or referral to resources.

Health system responses to unmet social needs still often occur on a patient-by-patient basis rather than through such a universal approach (Frazee, Lewis, Rodriguez & Fisher, 2016). Health care providers who engage in screening efforts struggle to shift from using data on social determinants of health reactively for individual patient care toward using data proactively to inform population health improvement strategies (Gottlieb, Tobey, Cantor, Hessler & Adler, 2016). This individualized approach may be related to the predominant methods for measuring outcomes within the health services sector; a review found over 500 distinct performance measures in use across the U.S. within the health system alone (Martin, Nelson, Rakover & Chase, 2016). Many of these measures tracked specific diagnoses or health conditions rather than whole-person measures of wellbeing (Riumallo-Herl, Canning, & Salomon, 2018). This fragmentation in performance measures and their related incentives has also become a focus in discussions of health system transformation and payment reform in recent years (Martin, Nelson, Rakover & Chase, 2016; “Approaches to Cross-Sector Population Health Accountability,” 2018).

The roots of incentive misalignment and sector fragmentation, whether financial or measurement related, have been recognized to reside partly within policy spheres as well as the health and social service organizations that respond to policy (Rogan & Bradley, 2016). State policymakers have suggested that “political incentives, related to institutional features such as interest group lobbying or short policymaking timelines,

may direct attention and resources away from opportunities to improve state health” (Rogan & Bradley, 2016, p.2). Best (2012) observed that since “ the 1980s and 1990s, single-disease interest groups [have] emerged as an influential force in U.S. politics... Disease advocacy reshaped funding distributions, changed the perceived beneficiaries of policies, promoted metrics for commensuration, and made cultural categories of worth increasingly relevant to policymaking” (p.780). Thus, fragmented health and social services, rather than being a deliberate consequence of policymakers’ strategic decisions, may be the default outcome of pluralistic policymaking processes and stakeholder advocacy in the absence of intentional efforts to reintegrate sectors.

These political issues point to inherent tensions at the center of population health improvement debates, relating to stakeholders’ conflicting beliefs about the proper balance of personal and community responsibility for health and the proper role of the state in promoting or coercing change (Gostin & Powers, 2006). Rose (2001) observed that “a large number of people at a small risk may give rise to more cases of disease than the small number who are at a high risk” (p.431). Thus, population health improvement strategies can be considered in terms of both the broad overall shift they create in the health of a population, as well as the relatively targeted benefits they create for individuals and groups within the population. Integrated population health improvement strategies that are most beneficial for the community as a whole may yield relatively few benefits when viewed from the perspective of a particular stakeholder group or individual (Benach, Malmusi, Yasui, Martinez & Muntaner, 2011). These distinctions matter

because they can lead to differences in the level of support or resistance a given strategy provokes among affected stakeholders (Steinmo & Watts, 1995; Kahn-Best, 2012).

The Social Construction of “Fragmentation”

Halley (1997) observed that “under conditions where many starting points are possible, whatever the substantive starting point for service integration (whether it is “service,” or “integration,” or “fragmentation,” or “neighborhood,” or “person”), a critical and fundamental question will be what are the ensuing boundaries: how are services bounded, how is the human service system itself bounded, how are neighborhoods bounded, and so on. The differentiations we make will influence how important questions of integrative effect...are ultimately framed, addressed and assessed” (p.165). Hasset and Austin (1997) similarly observed that “while these [service integration] labels may signify different levels of intensity or differing focus, they all refer to efforts to reduce or eliminate divisions or boundaries between categorically defined and provided services” (p.9-10).

Theories of the policymaking process have provided some insights into how and why distinct boundaries have emerged, fragmenting the delivery of health care, public health and social services, and the populations they are intended to reach. Russell, Greenhalgh, Byrne and McDonnell (2008) argued that health policymaking is often presented as a type of “decision science,” using reason to weigh options, when the design of policy is actually “the struggle over ideas”, and as such, the selection and weighing of evidence is only a part of the policymaking process. The use of language to “name and frame” problems is a persuasive and rhetorical process, not a logical one (Russell, et al.,

2008). Bacchi (2009) similarly argued that problem structuring is itself an intervention into a situation and recommends asking “what is the problem represented to be?” rather than “what is the problem?”

From this perspective, the focus on health “determinants” (including social determinants of health) that has become so central to population health improvement debates over the past century may have subtly shifted the policy problem frame away from whole people to one in which “determinants” might be thought of as individually modifiable health parameters that can be targeted – whether at the individual level or at the community level - through narrowly designed interventions (for example, nutrition interventions for individuals with food insecurity, or housing interventions for people who are chronically homeless). Theories of complex adaptive systems suggest that health – whether the health of an individual or the health of a population – may not be “decomposable” into discrete determinants in this way, yet this problem frame is reflected in the widespread compartmentalizing and consideration of narrow population health improvement strategies and interventions oriented toward single health determinants (Stange, 2009a, Riumallo, et al., 2018).

Social Construction Theory (SCT) (Schneider & Ingram, 1993) has also suggested that policies (and their implied problems) create target populations or groups by carving out specific people and organizations to receive benefits or burdens, and in this way, “policy creates politics, not the other way around” (Sabatier & Wiele, 2014, p.106). “Population health” invokes populations, and policymakers have to define these populations somehow (geographically, socioeconomically, by insurance coverage, etc.)

as a target group. The segmenting of populations according to insurance status and other eligibility criteria becomes a barrier to groups of stakeholders coming together to improve population health (Eggleston & Finkelstein, 2014). Once these divisions exist, there is evidence of strong pressures for policymakers to construct policies that favor groups who are socially powerful, positively constructed (i.e. framed in a positive light), or both, while shifting the burden of these changes to groups with less social power or negative social status (Schneider, Ingram, & deLeon, 2014).

When health policy debates focus on improvements in single determinants of health or narrow target populations rather than broad population health outcomes, the policy debate may be reframed in terms of smaller and less diverse groups of actors. The debate around policy solutions then advances in ways that are influenced by the positive or negative social construction of these groups (Furlong, 1993). This dynamic also plays out in the consideration of who should bear the cost or burden of health interventions – for example, in policy debates about opioid addiction, Cooper (2004) found that low-income groups were more often blamed for their addictions while higher-income groups were cast as victims of their conditions, influencing perceptions of who was responsible for acting. There is a broad body of policy literature demonstrating the influence of these varying social frames in the design of U.S. health and social welfare policy, and in particular, how these frames contribute to the widespread variation in eligibility criteria, benefit design and program administration seen across different health and social care programs (see Shneider, et al., 2014 for a comprehensive review of this literature).

An equally important but less noted element of Social Construction Theory lies in its proposition that the positive or negative social construction of groups influences the experiences of participants when they engage with service providers after a policy has been enacted, and the likelihood that they will mobilize in support of, or opposition to, future changes in those policies (Lawrence, Stoker, & Wolman, 2013). Public support has generally been higher for narrow, “particularistic” health and welfare policies targeting higher-status groups than it has been for “universalistic” policies that generate broadly distributed benefits to both higher-status and lower-status groups (Lawrence, et al., 2013). The degree to which policies promote participatory governance and self-efficacy within a program’s design appear to directly impact the rates at which marginalized target groups participate (Bruch, Ferree, & Soss, 2010).

These findings have relevance for the integration of health and social services because they suggest that part of the challenge of overcoming siloed sectors may lie in the fact that highly fragmented policies have, over time, developed narrow groups of stakeholders who may have difficulty mobilizing collectively to advocate for broad health improvements, but may be more easily activated and mobilized in defense of their own narrow concerns affecting their issue area (Kahn-Best, 2012). Related to this idea, certain socially constructed target groups may represent a relatively small subset of the population as a whole but account for significant demand for certain services (such as people routinely labeled “high utilizers” in health care); while the wellbeing of this group may have broad implications for the health sector as a whole, their small numbers may mean that their needs go largely overlooked in debates about which policies should be

prioritized for a larger “constituency” (Hassett & Austin, 1997). For example, the health sector has rarely mobilized in the face of policy threats to programs such as food assistance or federal housing vouchers, despite the clear implications of these programs for health care costs among certain populations. Whether or not health system organizations should engage in such advocacy efforts as a substitute for redirecting their own resources toward social programs was an emerging debate within health services literature at the time of this research (Katch and Bailey, 2020).

Promoting population health requires attention to both the relative health of these subgroups within the population, as well as the health of the population as a whole (Rose, 2001; Benach, et al., 2008; Wyatt, Laderman, Botwinick, Mate & Whittington, 2016). Yet because social welfare policies typically distribute benefits and burdens by constructing social groups, the organizations and sectors that provide health and social services face significant pressure to align their service delivery in response to these same groups and their associated benefits (or likewise, to respond to service gaps that may emerge when some groups are treated more favorably than others). Freeman’s (1984) Stakeholder Theory has suggested that organizations create and destroy value for stakeholders through their activities. Their stakeholders can be voluntary (engaging willingly) or involuntary (being put at risk), and organizations try to minimize tradeoffs by pursuing activities that align with the greatest number of stakeholders’ interests while destroying value for the least number (Mitchell, van Buren, Greenwood, Freeman, 2015). Organizations whose missions are narrowly defined or particularistic may find it easier to

generate support, while avoiding opposition, than organizations that aim to work on behalf of broad and diverse groups of stakeholders.

Writing about service integration, Roehrich and Caldwell (2012) observed that phenomenon that organizations “unbundle” their services in order to better manage the risks of individual activities (and where possible, delegate them to others), but this unbundling creates “stakeholder silos” around specific steps in a process rather than the process as a whole. Mintzberg (1980) observed that when departments, levels or groups within an organization become specialized and adapted to specific sub-functions of a larger process, they can then create tension with one another. The approach an organization takes to defining its target “population” may vary – in some cases geographically defined, in other cases defined by social factors such as income, race, age or gender, and in still other cases defined by transactional distinctions such as “clients,” “members or “patients” (Cashman, 2016). These dynamics, and the resulting differences in purpose and target populations, also provide insights into why health and social service organizations and their sectors are perceived to be fragmented and have difficulty aligning their efforts.

Organizational Theories of Risk and Adaptation

Social Construction Theory suggests policies are a tool through which social groups are constructed, and benefits and burdens are distributed among them, and thus changes in policy pose new risks and rewards to specific groups of stakeholders (Schneider & Ingram, 1993). Organizations strategically adapt to these shifting risks and opportunities and this adaptation can lead to differences in organizations’ strategic

orientations, resource dependencies, and risk exposures that appear as “differentiation” or “fragmentation” when organizations interact with each other (Scott, 1987; Perrow, 2014, Mitchell, et al., 2015).

Environmental Uncertainty and Organizational Differentiation

Many contemporary organizational theories reflect a common theme that adaptation is a form of risk avoidance in response to environmental uncertainty (Scott, 1987). This recognition that organizations adapt to their environments emerged within the school of “contingency theories” of organizational behavior beginning in the 1960s, marking what Scott (1987) called the transition from “closed” to “open” conceptions of organizations. For example, Contingency Theory (Lawrence & Lorsch, 1967) suggested that environments could be uncertain in terms of their rate of change, the availability of information, and the length of feedback delays between actions and results. Mintzberg (1980) posited that organizational adaptation could occur in response to diversity in an organization’s market, disparities across the environment that require unequal responses, varying degrees of autonomy and even trends that could make certain managerial approaches more acceptable than others. Palmer and Wiseman (1999) characterized environmental uncertainty as complexity (the number and size of the system’s parts), munificence (the degree to which a system’s resource base could sustain the system over time) and dynamism (the rate of change and volatility within the system). In addition to these “technical” environmental uncertainties, Scott and Meyer (1991) posited that organizations could face “institutional” pressures related to their norms, practices and structures.

Hovmand and Gillespie (2010) differentiated between changes in an organization's strategies and tactics, with tactical reorientations focused on quality and efficiency of an organization's existing activities, and strategic reorientations relating to "an organization's capabilities, resource dependencies and long-term processes" over time (p.80). Biroscak, et al., (2014) further differentiated between an organization's "strategic orientation" (or current set of activities) and its "required orientation" (the set of external criteria that stakeholders use to judge an organization's perceived effectiveness). They argued that the pressure for managers to strategically re-align, whether technically or institutionally, increases as the gap between an organization's current and stakeholder-required strategic orientations grows. Palmer and Wiseman (1999) similarly noted that managers' willingness to take risks appears related to the perceived gap between organizational goals and performance, with higher performing organizations less willing to take risks.

Reger and Sigismund-Huff (1993) also noted that an organization's strategic orientation need not necessarily be strategic in the normative sense –some strategic orientations are mal-adaptive. Differences in strategic orientations also mean that organizations become differently vulnerable, or exposed, to changes in environmental conditions, depending upon the conditions to which they have adapted; for example, Scott and Meyer (1991) observed that organizations can achieve efficiency by reducing variation in their services, or by having highly effective services. Those that do so through reduced variability are less susceptible to environmental shocks and changes in resource streams, but they are also then less susceptible to pressure to improve.

Interactions between organizations and their environments generally reflect flows or exchanges of resources, information, ideas, or values across boundaries between groups (Kadushin, 2012), and can be conceptualized in multiple ways, including: 1) as transactions or exchanges between two directly-connected organizations within a network; 2) as indirect exchanges between two organizations that pass through intermediaries connecting them within a larger field; 3) as symbolic or indirect connections that influence organizations through their participation in functional industries or groups; and 4) as symbolic connections that link organizations within sectors according to shared culture, symbols or narratives (Perrow, 2014). The majority of interdependencies within an organizational network may actually be intangible or relational ones, rather than overt or observable transactions or agreements. Case studies of health and social organizations have suggested most inter-organizational connections reflect exchanges of practices, ideas and norms rather than materials or resources (Perrow, 2014; Warren, Rose and Bergunder, 1974).

Williams (2002) described several types of interdependencies that can exist within a group, including “pooled” interdependencies (where actors are indirectly connected by their mutual efforts toward a common outcome, but no actor’s effort is directly influenced by another’s); “sequential” interdependencies, where the outputs of some actors’ efforts become the inputs for others; and “reciprocal” interdependencies, where a sequential chain of interdependencies circles back on itself, meaning no partners are clearly “upstream” from others. Sequential and reciprocal interdependencies are “contingent” situations, in that one organization’s behavior can change the value of the

strategic options that other partners have to choose from, giving rise to opportunities for both cooperation and competition (Williams, 2002). Lo Nigro and Abbate (2011) described the dimensions of “network risk” that arise with contingent interdependencies, including both “performance risk” (arising indirectly from environmental conditions and directly from connections to other organizations), and “relational risk” (including trust, asymmetric information and reciprocity). Pfeffer and Salancik’s (1978) Resource Dependence Theory suggested that the need for resources creates a network of interdependencies among organizations, and that managers attempt to gain power over these interdependencies through their interactions with others.

Organizational networks that rely on specialized infrastructures also bear risks that simple markets do not. Transaction Cost Economics (TCE) theory suggested that differentiation makes organizations within a system “bilaterally dependent” upon one another, because those that produce complex goods and services typically need specialized infrastructures to do so, but the required investments in these specialized infrastructures limit the number of organizations that will enter a market and also increase the cost of leaving a market (Williamson, 1973 and 2002). TCE theory suggested bilaterally dependent organizations attempt to protect specialized assets from a variety of risks and uncertainties by entering into contracts and operating agreements, but these agreements present new risks that must also be managed (Williamson, 1973). For example, transactions over long distances may be inherently less efficient than those over close distances, reducing the number of true partners with which an organization can transact. To minimize time inefficiencies, organizations may cluster or co-locate services,

further deepening their interdependence and exposure to opportunistic behavior of partners. Agreements to reserve dedicated capacity within a partner's production system operate much the same way, reducing uncertainty about ability to respond to future demand while increasing the likelihood that the agreement can be exploited (Robinson, 1994).

Managerial Perceptions of Risk

Milliken (1987) noted that in the organizational literature, the concept of "environmental uncertainty" as a source of risk has been used, sometimes confusingly, to describe both the state of the environment, and the perceiver's incomplete understanding or information about the environment. Beck explored this tension between constructivist and realist conceptions of risk in his landmark *Risk Society* (1992), in which he argued that risk is both the contemplation of hazards that have not yet occurred (and thus, can be understood as mentally or socially "constructed") and a force that shapes behaviors and actions (and thus has consequences that can also be considered from a realist perspective). Palmer and Wiseman (1999) similarly noted that while the concepts of environmental risk (such as uncertainty in resources) and managerial risk taking/avoidance are distinct concepts, environmental risk drives organizational adaptation primarily through its impact on managers' perceptions and decisions rather than via direct influence on organization structure or function.

The field of decision analysis breaks the concept of decision-making into three generic parts: the degree of uncertainty, the risk preferences of the decision maker, and a situation's structure (or the "problem space" for the decision); the first two concepts

relate to the position, cognitive habits and worldviews of the decision-maker, while the third relates to the situation and the factors being perceived (Howard, 1989):

- *Uncertainty*: Milliken (1987) defined uncertainty as “an individual’s perceived inability to predict something accurately” either due to lack of information, or an inability to distinguish between relevant and irrelevant factors (p.136). Williams (2002) similarly distinguished between risks that are “aleatoric,” arising from situations or processes that appear to be inherently probabilistic or unpredictable, and “epistemic,” risks that appear uncertain because of imperfect or incomplete information (and that could, in theory, be reduced through additional information gathering). Mitchell, et al. (2015) observed that managers weigh the uncertain value of both in action and inaction (e.g. missed opportunities). Adam, Beck and van Loon (2000) wrote about the paradox of uncertainty that emerges within knowledge-based societies, where new information that advances understanding of (and reduces uncertainty about) a phenomenon can also lead to heightened awareness about the ways we lack information or understanding (and thus introduce new risks that may be perceived). By extension, lack of information can alternately be perceived as a reason to act, or a reason to refrain from acting, depending upon how uncertainty is perceived by a given actor (Adam, Beck & van Loon, 2000).
- *Preferences*: The risk of a particular situation can be perceived differently by different individuals as well as reacted to differently (Johnson, 1993). Savage (1993) differentiated between the “dread” (undesirability) attached to an event, and the perceived “exposure” that a given person has to the event, noting that these dimensions of risk vary among people (including according to their demographic characteristics). Rejecting the idea that individuals perceive events in terms of discrete risks and rewards, Gregory and Mendelsohn (1993) wrote that “...risk ratings appear to be “net” ratings by individuals of whether [an event] leaves them better off or worse off...People may not hold separate risk and benefit categories as part of their mental models of a proposed option” (p263). Sandman (1989) noted that risk preferences of managers may be shaped by both the perceived impacts of a given outcome, as well as a risk’s visibility and potential to generate a strong reaction among an issue’s stakeholders. Beck (1992) introduced the idea that risk preferences are defined not only by individuals’ mental models, but by societies’ “specific rules, institutions and capacities that structure the identification and assessment of risk in a specific cultural context” (or, more

simply, how societies organize their responses to risks) (p.221, Adam, Beck and van Loon, 2000).

- *Problem Spaces*: Situations can be uncertain in multiple ways, such as: 1) uncertain probabilities of events, 2) uncertain causal relationships among risk factors or variables; and 3) uncertain outcomes of a decision (so called “response” uncertainty) (Milliken (1987). To these dimensions of uncertainty, Howard (1989) added the complexity of a situation, derived from the number of variables and length of time over which interactions occur. Together, these dimensions of uncertainty, and the connections among them, form what Milliken (1987) called the “problem structure” of a situation. This structural view of problems allows for the conceptualization of managerial decisions as dilemmas or games that play out within organizational systems (as will be discussed in the following section) (Zhou, Lu and Liu, 2013).

Lax and Sebenius (1986) noted that “negotiation is a way of life for managers,” who navigate both explicit bargaining situations as well as more tacit negotiations “with those whom they cannot command but whose cooperation is vital, including peers and others outside the chain of command or beyond the organization itself” (p.1-2). They defined negotiation as “a process of potentially opportunistic interaction in which two or more parties with some apparently conflicting interests seek to do better by jointly decided action than they could otherwise” (p.87). Transaction cost theory similarly argued that managers are motivated to minimize their organizations’ transaction costs in their interactions with others, and these transaction costs need not be financial, but encompass all the inherent “transactional factors” that make some interactions more complex than others, including uncertainty and the risk of opportunism (Williamson, 1973).

Lax and Sebenius (1986) described “interests” as the basic measure, currency, or raw material of organizational negotiations; they noted the importance of distinguishing between the surface issues of a given negotiation or exchange, and the subtler underlying

interests that may be at stake such as an organization's reputation, precedent, relationships, strategy and fairness, which depend on stakeholder perceptions and are subjective. A network-based conceptualization of groups of organizations allows for heterogeneity of risk preferences and interests among stakeholders (Cross, Dickmann, Newman-Gonchar & Fagan, 2009).

Reger and Sigismund-Huff (1993) noted that managers make simplifying assumptions about the intentions of other organizations including grouping competitors (generalizing from individual competitors to strategic groups of competitors), elaboration (embellishing incomplete information about competitors with assumptions), and interaction (the sharing of, and relying on, information and assumptions from others within one's field or industry). Managers may have difficulty assessing the intentions of others for several reasons, including "fuzziness" in how they group organizations or because some organizations are outliers or "strategically idiosyncratic" and do not fit the overall pattern of their industries. Organizations also engage in deliberate obscuring of their strategies for competitive advantage, and leadership changes or shifts in strategic orientation can create perceptions that an organization is "in flux" (Reger & Sigismund-Huff, 1993). To cope with uncertain information about the trustworthiness of potential partners, organizations build their "brands" – reputational assets that signal they can be trusted – but these reputational assets must also be protected by managers and thus reduce the number of acceptable partners with whom an organization can safely "do business" (Robinson, 1994).

There is also variation in the perceived trustworthiness of partners that gives rise to differences in negotiating and partnering preferences across sectors (Hogg & Varda, 2016). Chen and Bozeman (2012) observed that the public, private for-profit and private non-profit sectors exhibit different levels of managerial risk aversion, attributed to differences in expectations for external accountability and differing levels of internal trust among employees. Torugsa and Arundel (2017) noted the public sector is more risk averse than the private sector because of heightened public and media scrutiny of its activities, the high perceived vulnerability of many target populations of government programs, and the conflicting philosophies about the proper role of government within public sector management. In their study of sector approaches to innovation, D'Este, Iammarino, Savona and von Tunzelmann (2012) wrote that the private sector may place a higher value on risk taking even in the face of failure, because it leads to “revealed barriers” that can only be identified through experimentation (distinct from “detering barriers” to innovation that cannot be changed). Torugsa and Arundel (2017) described these revealed barriers as a type of organizational learning that is forfeited when organizations do not experiment (noting that some managers perceive this forfeiture of knowledge as a risk in itself). Prospect theory also suggested that once an event has occurred, people will tend to regret losses more than they value gains (Kahneman & Tversky, 1979).

These theories of risk management and risk avoidance within organizations share a common thread: in assessing organizational behavior in the face of risk, it is not only the impact and probability of uncertain outcomes that matter, but the degree to which

information (particularly information about the actions of others) is known or knowable, how managers' perceptions of potential partners vary, and the values that managers attach to possible outcomes. Rather than assuming managers behave rationally in the face of uncertainty and risk, Zimmerman (2013) noted:

“...individual behavior flows from cognitive habits, either directly through social referencing, rules of thumb, or automatic behaviors; or indirectly through the shaping of rationality itself by framing or heuristics. Although behavior does not arise from individually rational optimization, it generally appears to be rational, because the cognitive habits that guide behavior evolve toward optimality. However, power imbalances shaped by particular social, political, and economic structures can distort this evolution, leading to individual behavior that fails to maximize individual or social well-being” (p.47).

Group Negotiations and Collective Action Dilemmas

Zimmerman's (2013) point that individual habits and interests, when filtered through social customs and power structures, can give rise to individual decisions that lead to collectively poor outcomes, is well explored in a field of research on “collective action dilemmas” (also called “social dilemmas”) (Dawes, 1980; Kollock, 1989; Feiock, 2013; Ostrom, 2015). Collective action dilemmas (CADs) are paradoxes where individuals have reason to engage in behaviors that lead, in the aggregate, to a social outcome that is less than ideal and, in some cases, unsustainable (Dawes, 1980). Ostrom (2015) explored collective action dilemmas in resource systems, noting that in systems where resources are finite, but cannot be easily controlled by restricting access, individuals sometimes consume resources in ways that result in the depletion or eventual collapse of the resource system unless they can construct cooperative governance mechanisms. The strategy that leads to the best outcome in a CAD often (though not

always) requires cooperative behavior of at least some, if not all, members of the group, and yet no member is individually incentivized to choose cooperation (Galán, et al., 2011).

These dilemmas can be conceptually modeled even when all of the underlying factors are not well understood. Modeling such dilemmas generally involves identifying the “elements” of the situation (including the parties, their interests, their “mental models,” their power, the negotiated issues, and their starting position) and the dynamics (including the rules of the game, the process of cooperating, and the process of “defecting” – resorting to competitive behavior) (Lax & Sebenius, 1986). Kollock (1998) described several general archetypes of CADs that vary depending on the value that actors assign to certain combinations of self-interested and cooperative behavior, including:

- Prisoner’s Dilemmas, originally conceptualized by Merrill Flood and Melvin Dresher at the RAND Corporation in 1950, and first named by Albert Tucker in 1951 (McCain, 2014). The default strategy in a prisoner’s dilemma is for an actor to defect, regardless of the action taken by others. In these situations, the nature of the dilemma leaves no ambiguity about what an actor is individually incentivized to do, regardless of the choice made by others.
- Contingency Dilemmas, where each person’s optimal choice depends upon the choices of others. In an “assurance” type contingency dilemma, the optimal strategy is for both actors to choose the same strategy (ideally to cooperate, but if not, then to mutually defect to the status quo); in a “chicken” contingency dilemma, the optimal outcome is for the actors to choose the opposite strategies, since neither mutual cooperation nor mutual defection are desired (Poundstone, 1992).

Kollock (1998) observed that many real-world CADs follow the general archetype of an assurance dilemma, because there is often a general sense that mutual cooperation of all members to manage a risk would be the ideal group behavior, but in

the absence of full commitment to an agreement from all involved parties, the best any individual member can do is to defect. Some contracting situations (such as health insurance or governmental social protections) are difficult to understand through the lens of these CAD theories because they include at least three parties rather than two (e.g., payers, service providers, and service recipients) (Howard, Wu, Caldwell, Fia and Konig, 2016). When multi-actor negotiations give rise to dilemmas, they are generically described as:

- Tragedy of the Commons Dilemmas, where the negotiation relates to the right of members of a group to access a shared resource that can be depleted with use, and the optimal strategy for a given actor is to maximize their access rights while ensuring that the rights of others are maintained within limits that do not exceed the “renewal” rate of the resource (Lloyd, 1833; Hardin, 1968).
- Public Goods Dilemmas, where the negotiation relates to the production of a shared resource that cannot be depleted with use, and the optimal strategy for a given actor is to minimize their individual costs for the production of the public good while ensuring that at least some others contribute (so the public good will not disappear) (Samuelson, 1954; Olson, 1965).

In these multi-actor CADs, all parties try to influence the behavior of the others and while a sector or network of organizations may remain constant in its relationships, the individuals, departments or groups who represent organizations and carry out their functions may evolve over time; thus, there is a temporal element to organizational networks and CADs (Howard, et al., 2016). Feiock, et al. (2013) noted the tension between competition and cooperation in CADs is also a fundamental challenge of not only organizations, but policy spheres, because when authority and power are fragmented across multiple sectors, governing bodies will typically attempt to maximize the policy gains for their own sector unless they have some incentive to work cooperatively. These

“Institutional” CADs can be horizontal (across geographic space), vertical (across levels of government) or functional (across sectors); some institutional CADs occur across more than one of these dimensions (Feiock, et al., 2013).

These archetypes of collective action dilemmas are simplifications, though useful for conceptualizing seemingly fragmented or mis-aligned behavior within a group. The dynamics of real-world CADs have been found to vary according to a community’s social structure, and researchers have noted the importance of understanding this social structure and social context when attempting to infer the dynamics of a CAD in a given real-world situation (Galán, et al., 2011). Exworthy (1998) argued that the health sector should be understood as a “relational market” because it operates “as both a series of economic transactions and as a set of social relations between purchasers and providers” (p. 457). Artz and Brush (1999) similarly described a “relational contracting” approach to the study of dilemmas that “...highlights the importance of sociological factors such as the behavioral norms between transactors” (p.338). These social “norms” or rules regulate the range of behaviors that are acceptable when organizations interact; at the interpersonal level these norms include 1) the clarity a manager has about their (and others’) responsibilities in an agreement and clarity about what they are empowered to do (or not do) to fulfill their role, and 2) actions that signal that a relationship is valued, such as sharing power and mutual planning (Marcos & Prior, 2017). At the organizational level, social norms manifest as the presence or absence of “harmonizing” actions to align interests, resources, activities and processes across organizational boundaries (Marcos & Prior, 2017).

Perrow (2014) noted that a key tension in this interest-oriented perspective of organizational behavior lies in the degree to which managers (or, more generally, “agents” or people) are assumed to be self-interested versus other-regarding in their decision-making, and how these “interests” are defined. Weber, Kopelman and Messick (2004) suggested the use of an “appropriateness lens” to understand behavior within collective action dilemmas that emphasized the inherently social nature of most exchanges – in other words, asking “what does someone like me [given my identity] do [given my social rules] about a situation like this [given my understanding of what the situation is]?” (see Figure 2.2). They suggested that while the literature on CADs builds primarily from a foundation of rational choice theory, this appropriateness lens more fully reveals the dynamics of a CAD when “the social dimensions of a dilemma are apparent and/or salient, and especially when social features are combined with strong norms” (p. 284).

Figure 2.2: The Appropriateness Framework (Weber, et al., 2004)

Miller and Whitford (2002) argued that the social dilemma literature was misguided in its assumption that self-interestedness was the default behavior of managers and organizations, and that trust (the expectation that one’s behavior – good or bad – will

be reciprocated by others) and reciprocity (the actual act of matching the cooperative or competitive actions of one's partner) were observed to be "default" human behaviors that also manifest at the organizational level. In *The Samaritan's Dilemma*, Stone (2008) observed that within the health sector, in particular, individuals may resort to acts of civil disobedience at risk to themselves when they perceive social or organizational rules that forbid altruistic or cooperative acts on behalf of others. These contradicting ideas of default behavior as altruistic or self-interested have been somewhat reconciled in Gift Exchange Theory (Akerlof, 1982), where actors build up networks of obligations as a kind of insurance, by consistently giving more than what is minimally required in a transaction or bearing more than their share of risk in an agreement, in order to insulate themselves from the risks posed by the potentially opportunistic behaviors of others (Miller & Whitford, 2002).

Risk Management through Cooperative Agreements

Marcos and Prior (2017) suggested that organizations (and their managers) may be "boundedly reliable" – attempting to be reliable in their agreements with others unless explicitly incentivized to behave opportunistically. Gunderson and Holling (2002) wrote that "some of the failures of complex resource systems...can be traced to differences among the worldviews or myths that people hold" (p.10). What has been labeled "opportunism" in this literature on CADs may alternatively be understood as risk avoidance strategies rather than deliberately opportunistic behavior. Crocker and Shogren (1994) noted that some actors have earlier, better, or less costly access to information or risk protection than others. Exworthy (1998) described the "positioned knowledge" that a

given actor has because of their embeddedness within a community, and how this knowledge is layered over and shapes negotiations. Such positional differences mean that some organizations are better able to protect themselves from risks and can also (whether intentionally or not) undermine other organizations' self-protection efforts by transferring risk to them, creating opportunities for conflict (Crocker & Shogren, 1994).

Nguyen, Garvin and Gonzalez (2018) wrote that organizations have four basic responses to risk: avoiding, transferring, managing or sharing it. Cooperative agreements become a central tool that organizations use to transfer, manage and share risks (Nguyen, et al., 2018). In situations where risks cannot be transferred among parties, there is a greater natural incentive to cooperate to achieve risk management and reduction, and policy incentives are often less necessary to promote cooperative behaviors (Crocker & Shogren, 1994). In contrast, in situations where risks are easily transferred among parties, it may be easier for actors to transfer risks to others than to truly reduce or mitigate risks; in these cases, governance becomes necessary to shift a group's tendency to rely on risk transferring rather than risk reducing activities (Crocker & Shogren, 1994).

Westley and Vredenburg (1997) wrote that in highly complex domains, effective cooperative agreements and their related governance structures may take many different forms. In their discussion of organizational risk management, Kim and Park (2014) distinguished between risk transferring agreements that occur when risk exposure is "sold" from one party to another through the purchasing of some sort of insurance, and risk sharing agreements, where parties mutually commit to allocate the costs or returns of an activity among them (typically without payments between parties). They noted that

both risk transferring and risk sharing agreements operate through risk pooling because of an underlying “law of large numbers” – while the probability of an event may be highly uncertain to a single organization, the probability of that same event becomes more certain for some organization within a larger group, and thus potentially more easily managed. By pooling risks, organizations trade the high uncertainty of their individual risks for the relative certainty of the group’s risk (Liu and Faure, 2018).

The traditional approach to risk transferring is through insurance – purchasing the right to transfer a risk exposure from an individual to the group through a “premium” (Kim & Park, 2014). Principal-agent theory posited that buyers of services are less risk averse than sellers, because buyers can diversify their investments more easily than sellers can diversify their income streams (Miller & Whitford, 2002). Thus, when two actors have different risk preferences, transactions between them are improved for both parties when the more risk-averse party buys “insurance” from the less risk-averse party (Miller & Whitford, 2002). Some so-called “risk-based contracts” stipulate that when an agreed-upon outcome falls outside an acceptable range (as defined by the contract), the party bearing the risk agrees to accept certain costs or forego benefits; the premium charged for such insurance is based on the risk buyer’s calculations of the probability of a risk and its potential harm (Garnick, et al., 2001). However, this approach is difficult or impossible in situations where risks cannot be well defined, measured or predicted even at the group level (Kim & Park, 2014).

Risk sharing agreements require less information about the probability or potential cost of a risk, and do not necessarily require a payment to participate in the

cooperative activity unless a risk materializes (in contrast to an insurance premium, which is paid in advance) (Kim & Park, 2014). Risk-sharing agreements also become necessary because agents are not passive recipients of risk transfers; they exploit loopholes (Howard, et al., 2016). Similar to insurance, risk-sharing involves the pooling of risks among a group in order to minimize risk-related costs; the aggregate cost of shared risks is spread among the participants rather than transferred to a third party (Kim & Park, 2014). Liu and Faure (2018) proposed a typology of risk sharing agreements that vary according to the immediacy of the protection provided (where costs are either spread immediately to the group when an event occurs, or only spread after the risk creator has exhausted their ability to cover the costs), and the timing of payment (before or after a risk occurs).

Benefits of Cooperative Agreements

Selsky and Parker (2005) observed that theoretical research on the purpose of cooperative agreements (or, more generally, “partnerships”) has emerged from many disciplines and fields. They described three “platforms” or perspectives, each with its own frameworks and language, including:

- a Resource Dependence platform, where “organizations partner voluntarily, primarily to serve their own interests (e.g., acquire needed resources) and secondarily to address a social concern” (Selsky & Parker, 2005, p.853; Pfeffer & Salancik, 1979; Hillman, Withers & Collins, 2009);
- a Social Issues platform, where “the issue is paramount, collaboration is either mandated or voluntary, and the partnership is designed to be issue focused” (Selsky & Parker, 2005, pg 853); and
- a Societal Sector platform, which suggests sectors can substitute for one another when needed, but have different philosophies, values, and languages that make them imperfect substitutes for one another (Selsky & Parker, 2005).

Much of the literature on organizational risk and collective action dilemmas is theoretically situated within Selsky and Parker's Resource Dependence platform (as they use this term broadly to refer to economic and transactional theories of cooperation, in addition to Pfeffer and Salancik's (1978) Resource Dependence Theory). A resource dependence perspective on CADs suggests cooperative agreements are coordinating strategies designed to reduce power imbalances, and thus work by shifting interorganizational dependence, reducing the number of competitors, diversifying resource streams and increasing an organization's bargaining power and information about its environment (Pfeffer & Salancik, 1978). Lasker, et al. (2001) argued that the basic value proposition of such agreements is synergy – "the power to combine the perspectives, resources, and skills of a group of people and organizations" (p.183). They wrote that synergy is the link between partnership function and partnership effectiveness – the "key mechanism through which partnerships gain an advantage over single agents in addressing health and health system issues" (Lasker, et al., 2001, p. 183). Cantor, et al. (2015) similarly discussed the idea of "portfolio effects" that can arise from multiple aligned and reinforcing interventions in a community for health, noting that there is a dose-response effect of health partnerships that is greater than the sum of the individual partners' efforts.

Kollock (1998) wrote that within the literature on collective action dilemmas, the many proposed solutions to CADs vary along two dimensions: 1) whether actors are assumed to be completely self-interested or take the outcomes of their partners into account, and 2) whether or not actors can change the overall structure of a collective

action dilemma and rules for negotiating within it. There are three resulting categories of solutions (Kollock, 1998), including:

- Motivational solutions that change how actors value the outcomes of others. These solutions typically assume actors are not entirely self-interested and that they give some weight to partners' interests, but that the structure of the collective action dilemma is fixed.
- Strategic solutions that make potential partners more easily identifiable and increase the frequency and transparency of interactions. These strategies assume actors are completely self-interested, and also that the nature of the collective action dilemma is fixed.
- Structural solutions that aim to change the "rules of the game." Some of these solutions assume actors are completely self-interested, and others do not.

Motivational solutions assume that actors can be swayed to more highly value the interests of their partners, either through communication to increase awareness of a situation's impact on others, or by reclassifying an out-group member as a within-group member of a social group to which an organization belongs (Kollock, 1998). Lax and Sebenius (1987) similarly noted that the two basic strategies for promoting an agreement fall into two categories: 1) to make the alternatives to agreement appear worse, and 2) to highlight or enhance the value of joint action. Managers' choices vary in their tactics, distribution of outcomes, and creation of externalities. People perceive costs and benefits differently when they are shared among a group rather than accruing to an individual; Kollock (1998) wrote: "The robust effects of group identity and the expectation of reciprocity [within a group] imply that such issues as the construction of group boundaries and the signaling of group membership will be of fundamental importance to the study of social dilemmas" (p.208). Groups or sectors have been described as containing core organizations that are tightly associated with that group's identity or

typical strategies, secondary organizations that follow the group's strategies inconsistently, and transient organizations that transition into or out of the group's typical strategies (Reger & Sigismund-Huff, 1993). The use of geographic boundaries to group service providers has been presumed to engender a higher level of voluntary trust and cooperation (Exworthy, 1998).

In contrast to motivational solutions, strategic solutions overcome collective action dilemmas by making potential partners more easily identifiable; making interactions more frequent; and increasing information about their behavior. Kollock (1998) noted that if most partnership dilemmas resemble assurance dilemmas, then a key question lies in how partners signal and detect their trustworthiness to each other. Centralized forms of governance allow for taking an ad hoc approach to risk management that deals with risks as they arise, while decentralized alliance models of risk management require the development of robust rules and objectives that are voluntarily followed by all (Guo, Chang-Richards, Wilkinson & Li, 2014). Lax and Sebenius (1986) observed that many groups initially adopt so-called "mandates that consist of a combination of substantive purposes to be accomplished, resources to be used, along with attached conditions and expectations" (p. 269). These mandates often involve a group adopting an aspirational narrative of common interests and shared purposes that mask the fact that they continue to negotiate within the agreement. Trust has been described as a kind of bilateral dependency, reflecting embedded knowledge of partners that builds up through experience working together and thereby reduces the uncertainty in transactions (Perrow, 2014).

Researchers within this strategic camp of CAD solutions have observed that agreements only matter if there are sanctions for breaking them and monitors to observe when this happens (Perrow, 2014; Ostrom, 2015). Because all parties are assumed to be self-interested, and all bear risk in the uncertainty that some partners might violate or exploit an agreement when the incentive to compete outweighs the benefits of cooperation, monitoring and enforcement activities are needed; however, for an operating agreement to be preferable to no agreement, the agreement must balance perceived costs and benefits, minimizing new costs of enforcement and lost autonomy while maximizing perceived benefits provided by the agreement (Wood & Gray, 1991). Lawrence and Lorsch (1967) noted that effective coordinating strategies are context-specific, and oriented midway between the strategic orientations of the two divisions they are bridging (with strategies to bridge differences in organizations' time and goal orientations being most important). Resource Dependence Theory suggested that in addition to mergers (vertical integration) and joint ventures (horizontal integration), organizations employ cross-organizational relationships among boards of directors, political action, and executive succession and rotation to increase control and information in their interactions with others (Hillman, Withers & Collins, 2009).

Motivational and strategic solutions both assume that the nature of negotiation (e.g. the rules of the game or underlying problem structure) is essentially fixed (Kollock, 1998). Structural CAD solutions assume that groups can also negotiate to actively shape the rules of the systems they exist within (defined as "...prescriptive statements that forbid, require, or permit some action or outcome") (Ostrom, 2015, p.39). Kania and

Kramer (2011) suggested that “rather than deriving outcomes by rigid adherence to preconceived strategies, a key tenet of addressing complex problems is to focus on creating effective rules for interaction. These rules ensure alignment among participants that increases the likelihood of emergent solutions leading to the intended goal” (p.10). In this way, structural solutions change the nature of a collective action dilemma, making rewards indivisible, articulating what is being shared and who has access to it, and increasing the perceived importance of small actions of individuals who might otherwise think their behaviors have little effect on an outcome (Kollock, 1998).

Ostrom (2005) proposed a typology of three nested levels of rules that can be changed within a negotiating dilemma. Operational rules govern day to day transactions and the technologies and mechanisms by which they are carried out. These operational rules are nested within collective choice (or policymaking) rules governing how organizations can (and cannot) construct operating agreements. Collective choice rules are further nested within constitutional rules governing rights, powers, and representation in a system as well as the collective social norms of behavior (Ostrom, 2005). Ostrom (2015) argued that actors are observed to overcome CADs because they negotiate not only along operational rules, but also at the level of collective choice and constitutional rules. Lax and Sebenius (1986) similarly wrote that the rules of the game managers play could be changed by 1) changing the perceived issues that are being negotiated (adding, subtracting, combining, and separating them), 2) altering the parties who are included in the negotiation (adding and subtracting parties to change the scope or scale), and 3) changing the interests at play (by evoking or avoiding interests through an agreement’s

design and impact). They defined power within a social dilemma as the ability to define and change the nature of the game and the options that are under consideration (Lax & Sebenius, 1986).

Costs of Forming Agreements

There is potential for system transformation across all of these nested levels of rules, but overcoming CADs through the use of agreements is fundamentally challenging because it introduces new risks, new initial costs in forming new governance structures, and new costs of maintaining these structures over time (Feiock, 2013; Ostrom, 2015). Calabresi's (2008) Cost of Risks framework described three types of social costs that emerge within cooperative risk sharing agreements: 1) the primary costs of risk management, such as an organization's cost to avoid a risk and monitor the compliance of others within an agreement, 2) the secondary costs of risk pooling (through sharing or transferring), and 3) tertiary costs, or the administrative costs of any new agreement. These costs exist even when governing bodies have aligned interests but are particularly burdensome when they do not align, and the risk of opportunism increases (Feiock, et al., 2013).

Partners must also negotiate the distribution of any mutually generated risks or rewards – what Steinacker (2004) called division problems. Lax and Sebenius (1986) described a negotiator's dilemma that arises for managers when they work collaboratively with others, writing that “no matter how much creative problem solving

enlarges the pie, it must still be divided; value that has been created must be claimed” (p.33). Yet the tactics used to claim, or take credit, for jointly created value can also undermine the relational norms that made the joint effort possible in the first place. Financial incentives in these situations may also backfire if they erode the intrinsic value that partners would otherwise attach to cooperation by marketizing it; the so-called “crowding out” hypothesis says that by attaching a financial incentive to an action, a signal is sent that the cooperative action being incentivized is otherwise unattractive (when actors may not have otherwise held this belief) (Miller & Whitford, 2002).

The perceived costs of such agreements are highly influenced by the relational norms in a group such as their communication style or history with a particular partner. Artz and Brush (1999) provided empirical support for the idea that increasing relational norms (including signaled willingness to collaborate, expectations of relationship continuity, and noncoercive communication styles) lowered perceived negotiating costs within an agreement. The perceived costs will vary substantially among partners depending on their starting position or so-called “no agreement option” (Lax and Sebenius, 1986). Scott and Meyer (1991) noted that some organizations achieve efficiency not through the provision of high value services, but primarily through reliability in their services. These organizations can exhibit high inertia – they are slow to change over time because part of their value is in their stability. The pressures or incentives required to overcome this inertia may be relatively steep when compared to organizations whose efficiency is tied primarily to the value or quality of their services. There is also a dose-response effect in risk-sharing agreements; the larger the share of an

organization's revenues that are structured this way, the more an organization's behavior will shift (Rosenthal, 2000).

New collaborative mechanisms also increase in transactional cost as the scope of the agreement and the number of involved partners increases (from informal networks, to contracts, agreements, working groups, partnerships, and 'constructed networks') (Feiock, et al., 2013). There is also evidence that the formation of small groups initially can lower the costs of organizing successively larger groups over time (Ostrom, 2015). Case studies have demonstrated that successful collectives are sometimes second order groups – they have emerged out of the organizing efforts of a smaller, earlier collective (Wood & Gray, 1991). Hassett and Austin's (1997) summary of Bruner (1991) observed a three-stage pattern of agreements within governmental collaboration, including 1) "First Generation" interagency councils and commissions for joint planning, 2) "Second Generation" funding and technical assistance for demonstration pilots, and 3) "Third Generation" pilot projects that were scaled statewide.

Costs of Maintaining Agreements

Maintaining collective action agreements within a group is also difficult because as the number of members increases, the effort required to influence group behavior and monitor their commitment over time also rises (Kollock, 1998). If sectors possess highly specialized infrastructures (as hospitals, community health centers, shelters, and emergency food distribution networks clearly do), then as the risks within the partnership increase, the complexity of operating agreements required to manage these risks, and the degree of oversight that organizations must subject themselves to, increases (Williamson,

2002). While more complex agreements may provide greater protection from risk within the partnership, members will also forfeit more autonomy over time when they opt into greater levels of accountability. Performance measures within contracts create new risks for organizations in two ways: in terms of the creation of legal liability, and in terms of the degree of uncertainty between a task and an outcome (Lo Nigro & Abbate, 2011). The length of an agreement appears to be a significant factor in health system leaders' decision-making about risk-sharing agreements; when agreements are too short, they are not perceived to be worth the cost, and when they are too long, the perceived uncertainty increases (Garrison & Neumann., 2015).

These theories suggest the fitness of a cooperative mechanism depends on both the perceived cost of entering into an agreement, and the likelihood that partners will continue to recommit to the agreement over time (Feiock, 2013). When the potential future returns from cooperation remain consistently high, informal efforts that reinforce a partner's social embeddedness within an agreement or network may be sufficient to sustain the agreement (for example, participating in working groups or voluntary councils). As risks (and by extension, pressure to defect) increase, participation must be reinforced either by more formally binding agreements or broader membership within the collective to increase the social cost of leaving (Feiock, 2013).

Ishihara (2017) modeled relational contracts in a network game where agents faced bonuses for teamwork, but the sum of all bonuses was capped so that it could never exceed the increases in performance from the cooperative effort; under these conditions, the optimal strategy was either highly individualized action (no teamwork) or highly

team-oriented (offering significant help to others). Smaller amounts of team-oriented actions were never optimal because the costs of new helping tasks were higher than the bonuses to organizations unless all organizations significantly shifted toward these helping tasks. Marcos and Prior (2017) observed that organizational relationships that decline due to opportunism and violation of social norms proceed through three stages: 1) unawareness, characterized by nascent or emerging differences in perceptions and mental models of a situation, 2) a divergence phase where these differences lead to observed conflict, behaviors become inconsistent and preferences toward benevolence shift, and 3) degeneration, where cooperative behaviors are replaced by competitive ones (Marcos & Prior, 2017). Williamson (2002) wrote that as organizations transition from simple contracts to increasingly complex agreements, the temptation to instead absorb or vertically integrate these activities rather than conducting them through partnerships also increases.

As reviewed in this section, perceived costs are complex, socially constructed, and context-specific – they vary within a group depending upon individual factors including identity, group membership and preferences, as well as structural factors including the social rules and incentives that members perceive in a given situation, and their perception of how those rules and incentives distribute any collective gains or costs. No strategy to reduce inter-organizational dependence or risk is ever entirely effective or permanent; instead, these strategies create feedback effects and can become more of a liability than an asset if they do not evolve over time as environments and membership change. For example, governance boards can become barriers to adaptation if their

composition does not shift in response to changing resource needs (Hillman, et al., 2009). In short, partnerships do not eliminate organizational risk – they transform it from one set of organizational risks into another set of risks.

Risk and Resilience in Whole Networks

The health system has been described as a Complex Adaptive System – it is dynamic and evolves over time at multiple levels and often in seemingly erratic or unpredictable ways (McDaniel, Lanham & Anderson, 2009; Fink, El-Sayed, & Galea, 2017). Complex Adaptive Systems can be considered as whole systems, as collections of nested and purposeful sub-systems, and also as parts within a larger supra-system depending upon the perceptual stance taken by the system’s perceiver (Lendaris, 1986; Zexian & Xuhui, 2010). From a supra-system perspective, “the health system” is a functionally distinct sub-system within a larger connected social system, characterized by shifting and sometimes unclear boundaries, blending into and co-evolving with other functional systems. The degree of connectedness or fragmentation within a complex system may be examined through the concept of “emergence.” Emergent properties are those that can only be observed or measured at the level of the whole system, and not within individual sub-systems (Zexian & Xuhui, 2010; Jayasinghe, 2015). The synergy that is said to constitute the value in partnerships and cooperative agreements (Lasker, et al., 2001; Cantor, et al., 2015) can be considered an emergent property. Partnership

synergy relates to how the cooperative actions of those within a group are worth more as a whole than the sum of their parts (Kania & Kramer, 2013).

Yet Perrow (2014) cautioned against casting all fragmentation in a system as a deficit, noting that systems are tightly or loosely interconnected depending upon the types of risks the system has evolved to withstand. Less densely connected (or more fragmented) systems are observed in a variety of natural and social contexts to exhibit greater resilience to cascade failures (e.g., when the failure of a small part of a network triggers the failure of other surrounding parts of the network in a “cascade”), while densely connected systems exhibit greater resilience to point failures (where the failure of a single point in a network can remove a critical pathway or connection and thus cause disruption to the network as a whole) (Navlakh and Bar-Joseph, 2014). Anderies and Janssen (2013) similarly noted that all complex social systems are essentially regulating feedback systems with robustness-fragility tradeoffs, where social rules and norms act to maintain the system in the face of shocks. They wrote:

“...policies, in the broadest sense, are rules...that translate information about a system (e.g., state of the environment, demographics, etc.) into action that feeds back into the system.” (p.527) “...the system modules are polycentric governance units, ecosystems, and infrastructure systems. The feedbacks are the soft infrastructure – the rules, norms and shared strategies that form the protocols by which the system modules interact.” (p.529) “Increasing robustness to one type of known disturbance necessarily increases vulnerability to other types of disturbances...Worse yet, these emergent vulnerabilities are largely hidden, revealed only by a system-level failure.” (p. 532)

The adaptive cycle of complex systems also provides a useful framework through which to understand this relationship between connectedness and vulnerability, and its relevance for the co-evolution of the health and social sectors (Stange, Ferrer & Miller,

2009). Connectedness is a dynamic property of systems; adaptive cycle theory depicts social systems that move between periods of growth and increasing connectedness, when systems organize and resources are consumed, punctuated by periods of disruption and renewal where systems break down and resources are released (Gunderson & Holling, 2002). This theory suggests that systems become increasingly interconnected (and rigid) as they mature, providing less potential over time for innovation. This increasing rigidity eventually gives way to a release phase – a rapid breakdown in previously stable institutions, policies and rules that makes new organizational forms and processes possible and mobilize resources in ways that old models did not allow (Gunderson & Holling, 2002).

There are three factors that influence system transformation in the adaptive renewal cycle: 1) potential for change, which depends on the stage of the adaptive cycle a system is in, 2) connectedness, which dictates how much each member is influenced by external factors versus things they control, and 3) the system's resilience to shocks, which decreases as a system becomes more mature and connected (Stange, Ferrer & Miller, 2009). It has been hypothesized that the American healthcare system has progressed through the four major phases of this cycle (reorganization, exploitation, conservation and release) since World War II and that the past decade may have represented a release phase after which the system is now reorganizing under new and previously impossible institutional arrangements (Stange, Ferrer & Miller, 2009).

Discussion and Implications for Communities for Health

This chapter concludes with a discussion of the implications of these theories for the perceived organizational risks in communities for health. The strategic differentiation and coordination challenges described in the organizational theories reviewed in this chapter are well-documented problems in the health and social sectors. Social investments such as affordable housing in the U.S. are financed through a patchwork of thousands of partners including local government, private nonprofits, for-profit developers and federal incentives (Wright, et al., 2016). Bylander (2014) observed that differences in these financing streams lead to “different languages” used by organizations across different sectors. Collaboration tends to be greater in assessment, assurance, and advocacy activities than in the pursuit or sharing of funding (Wholey, Gregg & Moscovice, 2009). Organizational learning opportunities and evaluation efforts are also fragmented across the health and social sectors (Kramer, et al., 2009). Health sector stakeholders have suggested that formal multi-sector risk sharing agreements are rare in the U.S. relative to other developed nations partly because of inadequate infrastructure to share data so that all parties have access to the information needed to manage the agreement (Garrison, et al., 2015). The Institute for Healthcare Improvement documented over 500 distinct performance metrics in use across the country within the health care delivery system alone, and recently called for fifteen consolidated measures that aim to span sector boundaries, documenting levels of community social support, disparities in infant mortality, disparities in high school graduation, and a measure called the “Societal Footprint” that is intended to capture a community’s per capita health and social care investments (Martin, et al., 2016).

The literature on MSHPs and communities for health exhibits characteristics of the collective action dilemmas reviewed in this chapter. In 2018, the “wrong pockets problem” described in the health systems literature (Roman, 2015), was explicitly linked to theories of collective action. Researchers suggested multi-sector collaboration to address social determinants of health was an example of a social dilemma, with organizations and sectors aiming to maximize their share of society’s population health resources for their own activities, to the detriment of the society’s welfare as a whole (Nichols & Taylor, 2018). McGinnis, et al. have (2002) similarly noted that many of the leverage points for action on social determinants of health lie outside of the health sector, and actors within the health sector face a lower bar in justifying new medical expenditures (that accrue to a narrow set of within-group partners) than they do for population health investments that accrue to a diffuse group of partners inside and outside the sector.

Organizational leaders may perceive a moral case for working in partnership on population health issues, but often do not see the business case for doing so (Purnell, et al., 2016). In a review of Pay-for-Success initiatives intended to promote population health improvement, Lantz, Rosenbaum, Ku and Iovan (2016) similarly noted that not all interventions saved money for the implementing partners even when they improved health, because savings accrued elsewhere to other organizations, and often in small amounts across a large number of agencies. Hester (2018) described the primary challenges of measuring population health improvement as not being able to quantify the

savings that are generated in other sectors and finding sustainable financing for partnership governance and infrastructure (Hester, 2018).

Perceived goals of collaboration are also observed to vary within multi-sector health partnerships, and in some cases reflect substantial differences between the stated purpose of an initiative and the individual goals of its members (Litt, et al., 2015). It can also be difficult or impossible to find shared definitions of partnership effectiveness because there is often no consensus about a partnership's goal or purpose. Roussos and Fawcett (2000) observed that the impact of collaboration could be measured according to the amount of change, duration of change, or penetration of change created by a health partnership effort. In a study of barriers to coordination between Accountable Care Organizations and local health departments, a key challenge was the mismatch in time orientation, with ACOs focusing on shorter term outcomes while others such as health departments measured success over longer time frames (Ingram, et al., 2015). Organizations with more power and with the longest history in multi-sector partnerships may also be the most likely to perceive a partnership as successful (Litt, et al., 2015).

Culture clashes, power imbalances and misalignment of professional values are also observed to be functional impediments across multi-sector health partnerships (Carswell, Manning, Long, & Braithwaite, 2014) and reflect some of the assurance challenges described within collective action dilemmas (Kollock, 1998). Nonprofit organizations are the most frequently reported partners of both public health agencies and health care providers, while funders and health insurers are among the least frequent (Bevc, Retrum, & Varda, 2015b). Yet network studies of MSHPs suggest that nonprofits,

health services providers and public health agencies all show a tendency toward preferential ties to their own organizational types even within diverse collaborative networks, which can lead to the perpetuation of silos within these organizational networks (Bevc, Retrum, & Varda, 2015a).

Factors such as trust, accountability and motives for participation have been described as overlooked factors within collaborative health networks (Varda, Shoup and Miller, 2012). Valente, Chou, & Pentz (2007) also found that emphasizing evidence-based decision-making within a multi-sector health partnership decreased the number of relationships between organizations. Trust was reported as the single most important factor by organizational leaders in a 2017 workshop on promoting MSHPs. They identified the need to make time for trust building and acknowledging lived experiences, local context and histories of structural racism within communities (“Multisector Community Health Partnerships,” 2017). Varda and Retrum (2015) found higher levels of trust and greater contribution of resources were associated with greater perceived success in multi-sector health partnerships, while greater diversity of membership predicted the degree of disagreement about success among network members.

Scholars have argued that relational contracting is better suited to social services than other types of public goods because of the difficulty of assessing complex clear links between interventions and outcomes; however, they note that relational contracting is at odds with the performance and accountability-based approaches to cross-sector contracting that have been dominant over the past several decades (Never & de Leon, 2017). While community-based nonprofit organizations are generally assumed to be

altruistic and frugal, governments are under tremendous pressure to demonstrate results from their service agreements with nonprofits (Never & de Leon, 2017).

In a critical review of the literature on collaboration, Milbourne (2018) observed that partnerships in the modern era have formed within a larger policy context where neoliberal ideals of competition, marketization and entrepreneurialism have often been explicitly embraced by policymakers. In this environment, the emphasis on organizational collaboration has subtly shifted from one in which partnership is said to be pursued because of mutual ideals to one in which partnership is pursued as a means for organizations to gain competitive advantage. The accompanying shift toward individuals as consumers and the promotion of market-based reforms of social welfare programs have also driven increasingly individualized (and some argue fragmented) services in spite of the emphasis on organizational and sector collaboration (Milbourne, 2018).

It is within this neoliberal context that the majority of contemporary research on cross-sector partnerships has occurred, and the tensions between these competitive and cooperative pressures may theoretically be understood through the lens of collective action dilemmas as the rules of the game in which organizations currently operate (Ostrom, 2015). Where policies currently encourage (and in some cases mandate) collaboration, they also require organizations to compete within a highly marketized contracting environment, and this contradiction is reflected in the risk management efforts of organizations. For example, risk sharing between funders and service providers through value-based payments in health services has been described as a functional substitute for the payer directly controlling managerial decision-making at the service

delivery level; it reflects a type of risk transfer to service providers in order to compensate for inability to monitor their activities (Rosenthal, 2000).

Health service organizations are observed to engage in similar risk transferring activities to their social service partners. Garnick, et al. (2001) noted that behavioral health services were often handled via carve out contracts rather than provided directly by health services organizations, and these carve out contracts typically transferred performance and financial risk to partnering social service organizations. Yet Garnick, et al. (2001) also noted that once these risk-transfer contracts were in place, switching to other vendors became relatively transactionally expensive for the contracting health service organizations and disincentivized future emphasis on the performance of the contracted social service agencies. This dynamic echoes Williamson's (1973) theory of bilateral dependency and small numbers bargaining in complex operating agreements.

As described earlier in this chapter, communities for health have been described as a portfolio approach to health promotion consisting of five key elements (Hester, 2018): 1) a set of evidence-based interventions to improve health determinants; 2) financial resources to support those interventions; 3) some selection criteria for how to prioritize interventions (with risk of failure proposed as one important dimension of these criteria); 4) the ability to capture, share and reinvest savings; and, 5) a convening structure (the "Accountable Health Community") to organize the efforts of various stakeholders (Hester, 2018). Describing the role of the Accountable Health Community in brokering and facilitating partnerships, Hester (2018) wrote that in a community for health's portfolio of activities,

“Each intervention should have a financing method that is selected based on considerations such as how well the characteristics of the intervention match the financing method’s desired time horizon for impact and acceptable limits on degree of risk....Building the portfolio involves first selecting an intervention and then engaging an implementation partner with the skills to operate the program. The Accountable Health Community then matches a financial partner based on tolerance for risk and time frame for achieving returns and closes the transaction by linking the financier to the implementation partner.” (Hester, 2018, p 572)

Within these discussions, it has not always been clear whether the “risk tolerance” of participants and the “risk of failure” posed by potential intervention options refer exclusively to financial risk, or to a broader and less well defined set of operational risks. The organizational literature reviewed in this chapter suggests that in successfully matching organizational partners and service providers while aligning their risks and rewards, communities for health may need to consider a broader set of risks than only financial risks, such as potential conflict with the goals of other organizational stakeholders, the risk of unpredictable or opportunistic behavior of partners, and the risk to an organization’s reputation, relationships, and long-term assets. Christensen (2016) also noted that incentives can be cultural (e.g. peer pressure or normative pressure) as well as financial. Yet some scholars have also questioned to what extent incentivizing genuine organizational collaboration is possible within the competitive contracting environment in which health and social sector organizations now operate (Milbourne, 2018). Mitchell, Van Buren, Greenwood and Freeman (2015) noted that the use of financial accounting and reporting mechanisms often incentivizes the consideration of only a small number of an organization’s actual stakeholders rather than the full number of stakeholders affected by an organization’s work.

Conclusion

At the time of this research, health system transformation efforts were encouraging greater collaboration among the health services, social services and public health sectors in order to de-silo the fragmented efforts of stakeholders and collectively address social determinants of health. In pursuit of this goal, Accountable Care Organizations, primary care clinics and others within the health sector were taking steps to establish screening and referral networks with social service organizations and public health agencies through multi-sector health partnerships such as Accountable Health Communities. Meanwhile philanthropic, policy and professional organizations were promoting the adoption of shared goals and unified measures of success within these collaboratives and exploring opportunities to align risks and resources in order to better incentivize collaboration.

Past efforts to integrate health and social services, many of which have failed to achieve lasting systems transformation, suggest that this unified, collective action may be a problematic or perhaps even unattainable goal. Even within seemingly unified multi-sector health collaboratives, silos have formed and perceptions of success and purpose have varied across time and space. Roehrich and Caldwell (2012) described a paradox that health and social service organizations face in strategic alignment: in order to provide integrated services, the participating organizations have to “unbundle” themselves and the specializations they have developed over time to manage the risks of their activities.

The literature reviewed in this chapter points to certain dynamics underlying these partnership challenges. In summary:

- Organizations adapt to environmental pressures; these pressures include policies that have constructed narrowly defined target communities and revenue streams. Organizational adaptation leads to differentiation in organizations' strategic orientations, assets, and resource dependencies. This adaptive differentiation creates discontinuities in organizational goals and strategies that can be perceived as sector fragmentation.
- This adaptive differentiation also means organizations and sectors are affected differently by policy or systems changes. Risk is conceptualized as the perceived potential impacts and probabilities of uncertain events, which can be viewed in a positive or negative light by stakeholders depending upon their mental models, preferences, and the meaning they attach to a particular change.
- Despite their differences, organizations (and their stakeholders) are interdependent and exist within a network of other organizations and social groups, with whom organizations negotiate. Negotiations pose risks for organizations, including unpredictable partner behavior, new costs, and uncertainty about the future. These partnership risks can give rise to collective action dilemmas, which are disincentives that together make cooperative behavior and strategic alignment difficult.
- Collective action dilemmas may be overcome in multiple ways. Organizations enter agreements or partnerships to attempt to gain control and protection from risks, but these agreements must be scaled to their specific context and purpose and evolve over time. Partnerships do not eliminate organizational and system risk; instead, they transform it from one kind of risk to another, and create new risk exposure.
- The cross-organizational synergy that is described as a goal of some partnerships can be viewed as an emergent property of a complex system – a characteristic of group behavior that may be more easily observable at the whole-group level than at the level of individual organizations within the group. A system's vulnerability (as a whole) to environmental changes is also a property of groups, influenced by the degree of connectedness and range of risk exposures that vary across a network. Whether or not these dynamics are visible to members, they also have implications for the resilience of a whole system.

To the extent that organizational stakeholders perceive value in collaboration, this value is mediated by factors including (but not limited to):

- an organization's identity, including its functional purpose and specializations, its history and reputation, the social construction of its stakeholders, and the bounded groups such as sectors or geographic areas to which it belongs;
- the rules that structure an organization's operating environment, including its options to collaborate or compete, and the expectations or social norms attached to these choices;
- the potential outcomes of cooperative action, including the potential for perceived risks to be transferred, managed or shared;
- the perceived likelihood of those potential outcomes as well as the meaning (beneficial or hazardous) attached to those outcomes; and
- the perceived costs of the cooperative agreement itself, and the extent to which they are perceived to be balanced with the benefits.

These mediating factors vary the perceived risk of cooperative agreements for partners and help explain why conflicting goals and definitions of success can arise within multi-sector groups. The issues of multi-sector health partnerships approach what the literature characterizes as a “mess” or “wicked problem,” because the perceived problems and solutions in a given multi-stakeholder network vary with the positionality of the perceiver within the system (Rittel & Webber, 1973; Lendaris, 1986; Howard, 1989). These positional differences have implications for the design of incentives or the modification of policies in order to align the strategies of health and social sector organizations.

The paradox of collective action dilemmas also suggests that actions that appear to generate organizational value or solutions at one level might actually create new risks or problems at other levels (Kollock, 1998), generating potential tradeoffs for the efficiency and resiliency of the system as a whole (Anderies & Janssen, 2013). Barriers

can also be identified at multiple levels: single organizations (or departments within those organizations), organizational dyads, or whole systems or societies (Linden, 2002), and each level points to different leverage points that could potentially be improved with targeted efforts.

As will be reviewed in Chapter Three, this study explored health and social sector leaders' perspectives on organizational risk and strategic alignment within communities for health. The research employed methods that aimed to understand individuals' perceptions of risk in multi-sector collaboration, how their perspectives varied across regions and sectors, and how variation in those perspectives may have influenced their decision making processes and outcomes as they considered whether to engage in the Accountable Health Communities project.

Chapter Three – Approach, Design & Methods

Overview

This chapter presents the research approach, study design and methods that were used to answer the question, “How are the organizational risks of strategic alignment perceived by health and social service leaders within communities for health?” As introduced in Chapter One, the aims of this research were to:

1. characterize the risks of strategic alignment that are perceived by partners in communities for health, as well as the perceived causes and sources of those risks;
2. compare the similarities and differences in how various stakeholders perceive organizational risks of strategic alignment;
3. explore how perceived risks shape negotiations and act as incentives (or disincentives) for organizations to strategically align; and
4. discuss the implications of these perceptions for policy or systems changes to incentivize organizational alignment within communities for health.

Building on the research overview and literature review in prior chapters, this chapter presents the research design and methods that were used in this study, and is organized as follows:

- an overview of how a “critical systems” approach informed the design of this study;
- a review of the Appropriateness Framework (Weber, Kopelman and Messick, 2004) that informed the theoretical foundation and constructs of interest for this study;
- a discussion of the rationale for the explanatory, concept-driven, multiple case study design that was employed;
- a description of the sampling strategies that were used to select and recruit case study participants from the Accountable Health Communities networks in Oregon;

- a description of the data that were collected, the methods that were used to collect, organize and analyze the data, and the steps that were taken (including through IRB review) to protect the research participants; and
- a preview of the organization of findings in Chapter Four, and how the research question and aims are addressed in Chapter Five.

All research protocols and instruments described in this chapter are presented in the subsequent appendices.

Systems Approach

The approach to this research was informed by the fields of Soft Systems Thinking and Critical Systems Thinking, which in turn have arisen from a broader field of operations research devoted to the study of the performance of systems (Ulrich, 2012). “Soft systems” research emerged in the 1970s following researchers’ recognition that the methods for studying and improving mechanical or “hard” systems failed to account for social factors and multiple (often irreconcilable) stakeholder perspectives that were sources of complexity in human activity systems (Jackson, 2010). In this research paradigm, a fundamental principal is that “systems are essentially conceptual constructs rather than real-world entities” (Ulrich & Reynolds, 2010, p.251). All “systems” (such as health systems) are individuals’ mental representations or maps of a situation that simplify and select elements for inclusion or exclusion from consideration (Ulrich & Reynolds, 2010).

Flood (1990, p. 204) described Critical Systems Thinking as “a broad notion of critical science employed with a systems perspective.” Ulrich (2012, p.1236) similarly defined Critical Systems Thinking as “an application of systems thinking that aims to support good practice in operations research and other applied disciplines with special

regard to contextual selectivity, that is, assumptions that shape the perception of problem situations.” Cooper (2003) noted that Critical Systems Thinking takes a subjectivist approach to the nature of social reality and thus allows for the idea that perceptions are expressed understandings of individuals’ situations, informed by their relative knowledge and power, as well as distortions introduced by self-censorship as a result of individual and group social norms. Both soft systems and critical systems approaches emphasize the importance of problem structuring as a key element of systems research, acknowledging that all problem structuring is inherently normative and subjective (Ulrich, 2012). Ulrich (2012) wrote that:

“...expert-driven problem definition, with its emphasis on analysis and objectivity, needs to be complemented with, and embedded in, a pluralistic, participation-driven, methodologically well-defined process of unfolding problems within their larger contexts and from multiple perspectives. There will often be no single, definitive definition of ‘the problem’, as there are usually options for defining relevant contexts and perspectives—the ‘soft’ nature of problems.” (p. 1234)

This process of unfolding problems in research has been undertaken through the use of Soft Systems Methodology (Checkland, 2000) and Critical Systems Heuristics (Ulrich, 1983). Soft Systems Methodology in case studies has evolved since its introduction in the late 1970s, and includes four overarching activities: 1) “finding out about a problem situation, including culturally/politically,” (Checkland, 2000, p.S21), 2) developing models of the situation (often through “rich pictures” or other visual representations of stakeholders’ perceptions, 3) exploring the desirability, feasibility, and universality of potential changes from stakeholders’ perspectives, and 4) pursuing

improvement (either through direct intervention, or through the sharing of information intended to inform intervention) (Checkland, 2000, p.S21).

Critical Systems Heuristics (CSH), similarly designed to elicit multiple perspectives on a situation, involves systematically surfacing stakeholders' unique mental models of a situation that can then be compared and contrasted (Ulrich, 1983; Ulrich & Reynolds, 2010). Midgley, Munlo and Brown (1998) note that CSH methods extend from the work of critical theorist Jürgen Habermas and aim to avoid privileging the perspectives of more powerful stakeholders by establishing an “ideal speech situation,” where all stakeholders' assumptions are equally questioned. Traditionally, this has been understood by critical systems practitioners to require “sweeping in” the perspectives of a broader range of stakeholders and setting perspectives of all stakeholders as equally central to the understanding of a problem, while also remaining pragmatic and mindful that an ever-expanding view of a situation yields diminishing returns for the prospect of action (Churchman, 1970).

“Boundaries” in CSH are understood to be value judgments about what (and who) should be included in the consideration of a problem and the relative merits of its potential interventions (Churchman, 1970; Rajagopalan & Midgley, 2015). In Ulrich and Reynold's (2010) classical approach, CSH involves two steps:

- unfolding boundary judgments, through the identification of the beliefs held by stakeholders about a situation (e.g. how the situation is, whether it is problematic, for whom, and why) and the assumptions that underlie these perceptions; and
- questioning boundary judgments, including a) reflection, or identifying where stakeholders perceive discrepancies between what is and what ought to be,

and b) discourse, or identifying where there is conflict among stakeholders' perceptions about what is or what ought to be (Ulrich & Reynolds, 2010).

In this way, boundary critique is a useful approach for operationalizing how stakeholders think (both similarly and differently) about the nature of a shared problem. By making the boundary judgments of stakeholders explicit, CSH provides a mechanism for understanding how certain stakeholders or concerns become marginalized or centralized in the consensus definition of a problem (Rajagopalan & Midgley, 2015). A given stakeholder's boundary judgments are traditionally elicited through interviews that explore four sources of influence (motivation, control, knowledge and legitimacy) across three domains (social roles, concerns or stakes, and problems) through a series of questions (see Table 3.1) (Ulrich & Reynolds, 2010, p.245).

Table 3.1: Traditional Boundary Categories and Questions of Critical Systems Heuristics, (Ulrich & Reynolds, 2010, p.245)

Sources of Influence	Social roles (Stakeholders)	Specific concerns (Stakes)	Key problems (Stakeholding issues)
Sources of motivation	Beneficiary: who ought to be/is the intended beneficiary of the system?	Purpose: what ought to be/is the purpose of the system?	Measure of Improvement: what ought to be/is the system's measures of success?
Sources of control	Decision maker: who ought to be/is in control of the conditions of success?	Resources: what conditions of success ought to be/are under the control of the system?	Decision environment: what conditions of success ought to be/are outside the control of the decision maker?
Sources of knowledge	Expert: who ought to be/is providing relevant knowledge and skills for the system?	Expertise: what ought to be/are relevant new knowledge and skills for the system?	Guarantor: what ought to be/are regarded as assurances of successful implementation?
Sources of legitimacy	Witness: who ought to be/is representing the interests of those negatively affected by, but not involved with, the system?	Emancipation: what ought to be/are the opportunities for the interests of those negatively affected to have expression and freedom from the worldview of the system?	Worldview: what space ought to be/is available for reconciling differing worldviews regarding the system among those involved and affected?

Theoretical Foundations

This research proceeded from a foundational assumption that the challenges of multi-sector health partnerships (the so-called wrong pockets problems and barriers to strategic alignment described in previous chapters) resembled collective action dilemmas and could be explored as such. Weber, Kopelman and Messick's (2004) Appropriateness Framework (introduced in Chapter Two) provided a useful theoretical lens through which to surface and compare actors' perceptions about strategic alignment and organizational risk in communities for health (see Figure 3.1).

Figure 3.1: The Appropriateness Framework (Weber, et al., 2004, p.284)

This research modified the traditional CSH approach, using the Appropriateness Framework (2004) for understanding decision-making in collective action dilemmas in place of the traditional CSH boundary constructs.

As reviewed in Chapter Two, the Appropriateness Framework links the study of collective action dilemmas to literature on human decision-making and, by extension, organizational behavior. The framework suggests that an individual's decision-making in a collective action dilemma flows from the intersection of their identity and certain situational cues (Weber, et al., 2004). The rules or norms of behavior that a given actor

perceives as appropriate depend on 1) an individual's perception of the situation, 2) their identity, and 3) the task structure itself. These dimensions combine to influence 4) the decision rules (or heuristics) that actors rely on to guide their behavior in a collective action dilemma. Within each of these dimensions there are several constructs that are discussed below.

Perceptual Factors

The Appropriateness Framework suggests that actors' decision-making is influenced by perceptual factors, or how they have defined or perceived the collective action dilemma they face (Weber, et al., 2004). In essence, individuals ask themselves "what kind of situation is this?" when deciding how to act. Their answer to this question depends upon an actor's 1) perceived causes of the situation, and 2) frames or interpretations. Causes relate to an individual's understanding of why a situation is the way it is, what relationships exist among the actors or activities in a situation, and who or what is responsible for creating the current and future conditions. Frames relate to the meaning that is attached to these causal attributions. For example, is the situation fair? If not, why not? What are the motives of others, and to what degree are they perceived to be trustworthy? Which potential outcomes are perceived to be an improvement and beneficial, and which are perceived negatively, from the perspective of the perceiver?

Identity of Stakeholders

As reviewed in Chapter Two, the organizational literature suggests that perceptions of a situation are intrinsically tied to the identity of the perceiver - her values, motives and context. In this case, identity includes both elements of individual identity

(reflecting the personality, values and other social characteristics of a person acting on behalf of an organization) as well as the identity of an organization that a person is embedded within and represents (for example, its stated purpose and specializations, reputation, stakeholders, and the sectors or geographic areas to which it belongs). History is also an important element, as individuals draw from prior experiences that may be more or less similar to their current situation when deciding how to proceed (Weber, et al., 2004).

Task Structure

The Appropriateness Framework suggests that in addition to dimensions of identity and perceptions of a situation, the task structure of a situation (e.g., the nature of the collective task to be completed) is an important factor in decision-making in collective action dilemmas. While the literature reviewed in Chapter Two demonstrated that perceptions of organizational risk influence actors' behavior in collective action dilemmas, it also revealed that the decision-making process itself (in particular, the decision-making of others) is a source of uncertainty. The task structure of a situation includes aspects of a group's social structure, such as its size, communication mechanisms and power dynamics. The task structure of a situation also includes the game-theoretic elements of social dilemmas discussed in Chapter Two; for example, the options each actor can choose from, the potential outcomes of such choices, the risks and rewards they face from certain outcomes, and the degree of uncertainty about the likelihood of those outcomes as well as the intentions of others.

Decision Rules

The Appropriateness Framework suggests an actor's perception, identity, and the collective task they face intersect to influence the decision rules or heuristics they rely on to guide their behavior in a collective action dilemma. Rather than being a process of rational deliberation, decision-making is largely the result of automatic or shallow processing, and decision rules are a means by which people "cope with potentially overwhelming flow of stimuli...rules simplify behavioral choices by narrowing options" (Weber, et al., 2004, p.283). A decision rule, in essence, is an answer to the question: "what does a person like me do in a situation like this?" (Weber, et al., p.282). Decision-making only rises to a level of conscious deliberation when 1) actors face a choice that is potentially inconsistent with their values, 2) when social expectations for appropriate behavior in a situation are unclear, or 3) when the structure of the situation itself is vague or ambiguous (Weber, et al., 2004).

These dimensions of decision-making (perception, identity, situation and decision rules) were summarized in Table 3.2. Ulrich's (1983) Critical Systems Heuristics constructs (Table 3.2) share similarities with the Appropriateness Framework (most notably, the emphasis both frameworks place on decision rules or heuristics). While it was not the researcher's intention to suggest these frameworks are the same, the areas of similarity are indicated in the right column of Table 3.2 to support the decision to use the Appropriateness Framework in a manner similar to CSH boundary critique when comparing similarities and differences in stakeholders' perceptions and judgments in this study.

Table 3.2: The Appropriateness Framework and Critical Systems Heuristics

Appropriateness Framework Constructs	Definitions and Examples	CSH Constructs
Identity		
Social Motives	The social factors that motivate or constrain the actor's behavior; their stakeholders (Freeman, 1984); what their stakeholders require of them (Biroscak, 2014); who they depend on (Pfeffer & Salancik, 1978; Williamson, 1973); their organizational interests, beyond the immediate situation at hand (Lax and Sebenius, 1986).	Purposes
History	The actor's and their institution's history; their history with their current partners (Wood & Gray, 1991; Bruner, 1991); previous partnerships and prior experience they are drawing from (Kadusin, et al., 2005).	
Gender (and other demographics)	The actor's gender, age, racial and ethnic identity, and education level; the social groups they consider themselves to be part of (Kollock, 1998).	
Personality	The personal factors that motivate or constrain the actor's behavior; the extent to which they value cooperation versus competition and consider the outcomes of others in their decisions (Kollock, 1998); whether they "self-monitor" the impact of their actions versus relying on others to do so (Weber, et al., 2004).	Worldview
Perceptions		
Causes	How a given actor defines "the situation" they are in; the problem they perceive themselves to be trying to solve (Bacchi, 2009); to whom they attribute responsibility for that problem (Weber, et al., 2004); who is perceived to benefit from cooperation, and who is burdened (Schneider & Ingram, 1993).	Beneficiaries
Frames	The meaning an actor attaches to the causes they identify (Weber, et al., 2004); which potential outcomes are framed as gains and losses, and why (Kahneman and Tversky, 1979); the dread attached to potential losses (Savage, 1993); the stigmatization of beneficiaries and services (Schneider & Ingram, 1993).	Measures of Improvement
Task Structure		
Response Options	An actor's perceived choices in the situation; the decisions they have to make and the time frame over which they are committing (Garrison & Neumann, 2015); the options they have for avoiding, sharing, managing and transferring risks (Nguyen, et al., 2018).	Resources
Protocols of Play	The "rules of the game" that govern actors' operations, interactions, and rights within the group; the rules they have to follow; what is monitored, by whom, and how; to what extent they know how others are being impacted as the situation unfolds (Ostrom, 2015).	Guarantors
Payoff Structure	The potential outcomes of participating; whether the gains or losses depend on everyone's decisions, versus the decisions of single actors (Kollock, 1998); the potential rewards and costs of	

	participating and <i>not</i> participating (Lax & Sebenius, 1986; Williamson, 1973; Mitchell, et al, 2015); how credit for success is claimed and how costs are allocated (Steinacker, 2004; Lax and Sebenius, 1986).	
Uncertainty	Uncertain probabilities, outcomes, or causal relationships; the sources of uncertainty in the operating environment (Milliken, 1987); the uncertainties in the partnership; whether uncertainties are epistemic or aleatoric (Williams, 2002); time delays (Howard, 2002); clarity about the (normatively) right thing to do (Weber, et al., 2004).	Decision environment
Power and Status of Group Members	The distribution of power and status within the group; whether power is perceived to be distributed equally or unequally; the “status” of various people in the group, in terms of their standing or social construction (strong or weak, deserving or undeserving) (Schneider & Ingram, 1993); what powers members have within the group, and what they have the ability to influence; who the leaders are; whose knowledge is valued; who decides what success looks like; how coercive leadership is perceived to be (Artz & Brush, 1999); who does not have a voice in decision-making; whose outcomes are not considered.	Decision-makers Experts Witnesses
Communication	How actors share or obtain information about others in the group, and the group as a whole (Kollock, 1998); what information is shared, and how; what information is valued and valuable; whether there is anonymity or transparency in the decision-making processes; how people signal their intentions to one another (Ostrom, 2015); how difficult it is to communicate with the group.	Expertise
Group Size	The size of the group, and whether members perceive it to be right-sized, too small or too big for its task (Weber, et al., 2004).	
Group Dynamics	The degree to which the group is perceived to be cooperative versus competitive; whether actors expect reciprocity (Miller & Whitford, 2002); whether they expect the partnership to continue into the future (Artz and Brush, 1999); whether individuals act anonymously when they act on behalf of their organizations; whether they are encouraged by their organizations to act defensively or cooperatively (Weber, et al., 2004); what others’ motives are perceived to be; whether others are perceived to be trustworthy (Reger & Sigismund-Huff, 1993) and the reasons why.	Emancipation
Decision Rules		
	Decision rules “offer boundedly rational people a way to cope with the potentially overwhelming flow of stimuli to which they are constantly exposed” (Weber, et al., 2004, p. 283) and can range from reliance on simple (and largely subconscious) heuristics to more conscious deliberation about “what a person like me should do in a situation like this” (p. 282).	Heuristics

Case Study Design

This study employed the CSH approach through a multiple-case study design in order to elicit and compare stakeholders' perceptions of strategic alignment and organizational risk in communities for health. The case study design was appropriate because the nature of the question, "How are the organizational risks of strategic alignment perceived by health and social service leaders within communities for health?" focused on the "how" of the situation, rather than questions of "what", "when", or "how many" that would have been better suited to other methods (Yin, 2009). The situation of interest, partnership within communities for health, met the criteria for a case study design in that 1) it did not allow for control or manipulation of behavioral events by the researcher, 2) it related to current rather than historical events, and 3) the boundary between the system of interest and its environmental context was not easily defined (Yin, 2009; Baxter & Jack, 2008). Instead, "reflecting on the boundaries of inclusion and exclusion in systems" is a core element of a critical systems approach (Midgley, et al., 2018, p.776).

Case studies can take a variety of forms depending upon the research aims and the role of theory in the research design. In some instances, the research question calls for an exploratory or grounded theory approach in order to develop a framework or model of the situation (i.e. the case) and the relationships of interest within it (Yin, 2009). In contrast, explanatory case studies seek primarily to link existing theory with a real-world situation in order to better understand either the case or the theory by testing one's fitness against the other (Løkke & Sørensen, 2014). While in practice, explanatory case studies explore

aspects of both cases and theory, the researcher's decision to make a theory the primary focus of the research casts the case as instrumental (or vice versa).

Løkke & Sørensen (2014) suggested that *system-driven* case studies are focused primarily on a real-world case and employ theory instrumentally to explore the case from various angles. System-driven case studies call for the use of a single case coupled with multiple theoretical perspectives (as was perhaps most famously employed in *The Essence of Decision*, where Allison and Zelikow (1999) explored a single case - the Cuban missile crisis - from three theoretical perspectives of organizations). This system-driven approach is contrasted with *concept-driven* case studies, which are concerned with refining or extending a theory by testing it against a range of real-world cases (Løkke & Sørensen, 2014). Concept-driven case studies broaden the range and variation in the cases while restricting the focus to one theoretical perspective in order to test a theory's fitness across a wider range of conditions.

This study employed an explanatory, concept-driven design, using multiple cases to identify the perceptions of stakeholders, and considering these perceptions through the lens of a single theory of decision-making, the Appropriateness Framework (Weber, et al., 2004).

Case Selection and Rationale

The Accountable Health Communities project in Oregon presented a rare opportunity to observe organizations across multiple geographically and socioeconomically diverse regions that were simultaneously engaged in developing new multi-sectoral partnerships under a common model for strategic alignment. Prior to its

participation in Accountable Health Communities, Oregon had been recognized as a national leader in policy innovation to spur cross-sector collaboration (Hargunani, 2017) making it a useful environment in which to observe multi-sector health partnership dynamics. For example, beginning in 2012 the state implemented overlapping reforms in its education and health sectors, including the formation of a Joint Committee overseeing the health and education sectors in 2012, the formation of its sixteen Coordinated Care Organizations in 2013 and sixteen Early Learning Hubs in 2015, and a goal of adopting aligned measures for developmental screening of children and shared accountability for kindergarten readiness (Hargunani, 2017). Additionally, Oregon had been an early adopter of alternative payment and coverage models through its use of Medicaid waivers dating back to 1994 (“Medicaid 1115 Waiver,” n.d.).

The Oregon Rural Practice-based Research Network (ORPRN), housed at Oregon Health & Science University, is a “statewide network of primary care clinicians, community partners and academicians dedicated to studying the delivery of health care to rural residents and to reducing rural health disparities” (Oregon Rural Practice-based Research Network, 2018). In 2017, following a national request for proposals, ORPRN was selected by the Center for Medicare and Medicaid Services (CMS) to be one of 32 participants in the Accountable Health Communities initiative, and the only participant from a west coast state (see Figure 3.2).

**Figure 3.2: Accountable Health Communities Participants
("Accountable Health Communities Model," 2018)**

The health and social service organizations that were engaged, directly or indirectly, in carrying out the screening and referral work of the AHC project, were the source of data for this research. A sample of organizational leaders from these organizations was purposively recruited to participate in interviews, surveys and document collection through the spring and summer of 2019. These methods and data are described in detail below.

As the convening organization for the Accountable Health Communities project in Oregon, ORPRN convened four regional AHC networks beginning in the spring of 2018. These communities for health were located in 1) the Yamhill Valley, 2) the mid-Columbia Gorge, 3) Southern Oregon and 4) Central Oregon. As is further described in Chapter Four, organizations in these regions were engaged to begin screening Medicaid and Medicare-enrolled individuals for unmet social needs, providing referrals to community partner agencies, and providing additional navigation support to a subset of

individuals with complex care needs. These “screening organizations” were primarily health service organizations that were engaged in the AHC project through formal agreements with ORPRN that outlined their roles and responsibilities, as well as eligibility for payments. While the AHC project in Oregon aimed to also engage social service organizations that individuals with unmet social needs were referred to (i.e. “referral organizations”), these organizations did not enter into formal agreements with ORPRN for efforts related to the AHC project.

The health and social service organizations that were engaged, directly or indirectly, in carrying out the screening and referral work of the AHC project, were the source of data for this research. A sample of organizational leaders from these organizations was purposively recruited to participate in interviews, surveys and document collection through the spring and summer of 2019. These methods and data are described in detail below.

Participant Selection and Exclusion Criteria

The primary unit of analysis in this case study could have been defined multiple ways with “cases” representing individual decision-makers, single organizations engaged in AHC activities, a collection of organizations within an AHC region, or the Oregon AHC project as a whole (see Figure 3.3).

Figure 3.3: Units of Analysis

Some AHC members were single-location organizations while others were statewide or multi-site organizations, serving multiple AHC regions and/or serving other geographic communities outside of the AHC regions. There was also variation in the positions held by the organizational decision-makers who were liaisons to ORPRN. This complexity and variation in organizational characteristics and representation within AHC was central to the research question. The constructs of interest in this study also occurred at varying levels. For example, perceptions manifested at the individual level, while network size and communication processes were properties of groups of organizations.

Yin (2009) has asserted that the units of data collection in a case study may be different from the unit of analysis, depending on the sources of the information. To ensure that data collection methods were matched appropriately with constructs of interest, this design allowed for the consideration of both cases and “embedded sub-units” of analysis (Yin, 2009). For this study, primary cases were defined as the four AHC regions because each of these regions shared some degree of purpose and decision-making across multiple organizations about the AHC project as a whole, yet possessed

unique geographies, demographics and histories. Individual decision-makers who represented organizations engaged in AHC activities were considered as “embedded sub-units” (Yin, 2009) within the case regions.

The concept-driven case study design (Løkke & Sørensen, 2014) supported the use of “maximum variation sampling” (Creswell, 2013) in order to expand the range and diversity of contexts across which theoretical propositions were tested. Resource constraints of the researcher did not allow for a multiple-case study that included in-depth data collection from every organization conducting screenings or all of their potential referral partners within all four AHC regions in Oregon while also completing the research in a timely manner. To ensure the feasibility of this work while adhering to a multiple-case design, a sub-set of health service and social service organizations was selected from the four case regions through purposeful sampling (described in further detail below). The focus of this study was on multi-sector health partnerships; therefore, the intent was to maximize the diversity of sectors and organizations represented in the final interview sample.

Health service organizations (HSOs) were identified as potential research participants beginning in April 2019, once organizations had begun patient screening activities. A list of HSO organizations that had entered into agreements to participate in the AHC project was obtained from ORPRN. This list of organizations was sorted as follows:

- AHC region – each organization was assigned to the AHC region(s) in which it was providing services. Some organizations were assigned to more than one AHC region due to their involvement in service delivery across multiple counties.

- Service type – through a review of websites or other publicly available information, the researcher categorized HSOs as primarily being one of the following types of service providers: 1) physical health care, 2) public health agency, 3) oral health care, or 4) care coordination program.
- Degree of involvement in AHC activities – in consultation with ORPRN, organizations were identified from the list that had completed initial AHC training and begun individual screening activities. Organizations that did not meet this criterion were excluded from the list of potential participants.

This approach resulted in a final list of potential HSO participants in each region.

Two to three HSOs from each region were selected for invitation into the study in order to 1) ensure maximum diversity of organization service type across the four regions, and 2) avoid duplication of organizations with the same service type within any single AHC region.

Social service organizations (SSOs) were identified as potential research participants beginning in June 2019. This later start was necessary to ensure that at the time of SSO identification, a sufficient number of individual referrals had occurred in each AHC region to allow for identification of at least two SSOs within each of the five priority AHC resource areas (i.e., food, transportation, housing, utility assistance and safety). ORPRN provided the researcher with access to community resource sheets that had been generated for screened individuals in the four AHC regions. Through review of these resource sheets, an initial list of prospective SSO participants in each region was developed.

The researcher made one modification to the planned SSO identification strategy after the development of the initial list of prospective SSOs. Upon review of the community resource sheets, it was apparent that the organizations listed as community

resources for food assistance were often emergency food box distribution sites (such as churches or public schools) that operated in partnership with a regional food bank that was responsible for the program or service. It was likely that any partnership activity occurring among organizations in the AHC regions would involve the food bank rather than its distribution sites; the researcher was aware of the nature of this service delivery model due to prior work in the emergency food assistance field in Oregon. When this issue was identified, the list of potential SSO participants was modified to replace food distribution sites with the regional food bank overseeing that site.

The list of potential SSOs was stratified and ranked in the same manner described for HSOs above, so that SSO organizations were assigned to an AHC region and categorized according to one of the five social service types. Following the same logic used to identify HSOs for recruitment, three to four SSOs were purposively selected from this list in each AHC region in order to 1) maximize variation in service types across the four regions while 2) avoiding duplication of service types within any single AHC region.

Table 3.3: Intended Sample

Partner Type	AHC Region				Total
	Columbia Gorge	Yamhill Valley	Central Oregon	Southwestern Oregon	
Health Service Organization	2-3 participants	2-3 participants	2-3 participants	2-3 participants	8-12 participants
Social Service Organization	3-4 participants	3-4 participants	3-4 participants	3-4 participants	12-16 participants
Total	5-7 participants	5-7 participants	5-7 participants	5-7 participants	Grand Total: 20-28 participants

This approach to identifying potential HSO and SSO participants was intended to result in the sampling frame displayed in Table 3.3. As will be described in Chapter Four, these goals for participant recruitment were achieved in all regions and in both HSO and SSO categories.

Participant Recruitment

An initial invitation (see Appendix A) was emailed to potential participant organizations' leaders to introduce this study, clarify the relationship of the researcher to the Accountable Health Communities project, and invite them to participate in the study. For HSOs, the invitation was sent using the primary contact information ORPRN had available for each organization's leadership. For SSOs, organizational leaders' contact information was found via their websites or other publicly available online records.

Recipients were instructed to forward the invitation to a person 1) who was authorized to respond on behalf of their organization indicating their willingness to participate in the study, and 2) who held a senior decision-making role with regard to the organization's community partnerships, in the event that the recipient of the email was not the appropriate person to respond. An emailed reminder invitation was sent directly from the researcher to non-respondents approximately five days and ten days after the initial invitation (see Appendix B). Prospective participants who could not be reached or declined to participate within two weeks were replaced with additional prospects from the rank-ordered list as needed until the intended sample was achieved.

When HSO and SSO leaders expressed interest in participating in the research, they were provided with additional details about the steps involved to participate in the

study, as well as a form explaining their rights and protections as research subjects (see Appendix C). Informed consent was obtained from all participants prior to their participation in any data collection activities. This step included answering any questions the participants had about confidentiality or how their information would be used during and after the research was conducted.

Data Collection

A brief web-based survey was administered to participants upon their recruitment into the study in order to collect basic descriptive and relational data on the organization and its community partnerships. A questionnaire (see Appendix D) was developed and administered using Qualtrics (2018), a web-based survey tool. The questionnaire was constructed in a manner to minimize the need for respondents to consult organizational records (Dillman, 2000). The questionnaire collected the following types of information:

- an attestation of consent to participate in the survey (see Appendix E)
- organizational characteristics including mission, budget size, service area and core services;
- past, current or planned involvement in multi-partner and multi-sector projects such as AHC;
- past, current or planned direct agreements to coordinate services with organizations from other sectors.

In addition to completing organizational surveys, an interview with the researcher was scheduled with participants following completion of the consent form. An interview protocol was developed using semi-structured interview questions (see Appendix F) (Russ-Eft & Preskill, 2009). Interview questions were designed with consideration for the CSH approach and constructs of the Appropriateness Framework (see Table 3.2).

Participants were invited to complete the interview in person, by phone or Skype depending on their preference and availability, and all participants opted to complete the interview by phone. All interviews were audio-recorded using a phone recording application, TapeACall.com, (2019), after obtaining additional verbal consent from the participant at the start of the interview. No participants declined to be recorded. In addition to interviews, relevant supporting documents such as Community Health Improvement Plans or other strategic planning documents were collected when these were suggested or offered by participants during the interview stage. These additional documents supported exploration of elements of organizational identity, causes and frames (see p. 100-101).

Recorded interviews were initially transcribed using a web-based transcription service, Temi.com (2019). Transcripts were then manually reviewed and refined by the researcher in order to correct any errors made by the computer-assisted transcription service due to poor audio quality or unclear speech patterns. To expedite the data analysis phase, the researcher also catalogued initial impressions of the transcripts, prepared research memos, and refined the qualitative codebook during this transcription stage. All interview transcripts and supplemental documents, as well as the researcher's notes and memos, were organized, stored and analyzed in a research database in ATLAS.ti (2013).

Analysis of Data

Data analysis for this study occurred in three stages and began after all participant recruitment and data collection had been completed. First, survey data were coded and quantitatively analyzed. Next, interviews and surveys were analyzed for inter-

organizational connections that informed the development of network maps. Finally, interviews and documents were coded and thematically analyzed as described below.

Surveys

While the primary purpose of survey data in this research was to provide organizational context to the researcher in advance of participant interviews, survey data were also analyzed and presented as results when these data could provide useful context for other qualitative findings from this research. Survey data collected in Qualtrics were coded to allow for segmenting responses at the AHC regional level as well as by sector (health services or social services). Survey responses related to organizational characteristics, services, and community partnerships were segmented and then summarized by sector and by region. These survey data were then visualized into charts using Microsoft Excel to aid comparison across regions and sectors and translation of findings (see Chapter Four).

Network Maps

A network map was developed for each of the four AHC regions to aid in the development of case descriptions and to qualitatively explore participants' understanding of the structure and boundaries of their inter-organizational networks (or the "task structure" in which they operated (Weber, Kopelman and Messick, 2004)). In keeping with the qualitative and subjectivist approach to this research, network mapping was intended to represent participants' expressed understanding (or "mental model") of their social reality, rather than an objective or complete measure of the region's community structure (Hollstein, 2011). The use of network mapping allowed for synthesis of multiple

participants' understandings of their community partners and social connections into a single "rich picture" representing their understanding of their community's social structure (Checkland and Poulter, 2010).

Prior to de-identification, all interview transcripts were reviewed for participants' references to other organizations and various community groups such as coordinating councils or regional multi-sector meetings. When these references occurred, a network mapping tool, Kumu.io (cite), was used to depict involved organizations or individuals as network nodes, and connections between them as links (or "edges"). Kumu.io was chosen for this process because it allowed for the emergent coding and mapping of a potentially unlimited range of connection types, and the inclusion of researcher notes and memos within the network map, in order to retain contextual details for later exploration. After all interviews had been coded and mapped in this manner, network maps were reviewed and qualitatively compared for similarities and differences across regions in how organizations were describing collaborative activities and experiences. This allowed, for example, for comparison of how multiple participants across regions described the role or involvement of the region's Coordinated Care Organization. De-identified network maps are included for reference in Appendix G.

Interviews

Following Creswell's (2013) approach, the qualitative analysis in this study involved the coding of interview transcripts and supplemental documents, the development of themes, and the display and comparison of themes. An initial codebook was developed that primarily consisted of thematic codes related to the constructs of the

Appropriateness Framework (see Table 3.2). These *a priori* thematic codes were supplemented with additional emergent codes that were developed during a preliminary reading of transcripts; these emergent codes were primarily descriptive in nature and intended to capture elements of the data such as participants' references to organizational characteristics or processes (Creswell, 2013).

All interview transcripts and supplemental documents were de-identified, loaded into Atlas.ti, and organized with document labels to allow for segmentation by AHC region or by sector. All data were then coded by the researcher in ATLAS.ti using the finalized codebook. The "Code Document Table" function was used in Atlas.ti to generate initial code reports; these code reports were segmented and reviewed by sector to identify emergent themes related to interview participants' understandings of strategic alignment and risk within AHCs (including themes related to identity, perception, situation structure and decision rules). Code reports were then re-segmented by AHC region and again analyzed and compared following the same process. The resulting themes were tabulated for comparison within cases (e.g. each of the four AHC regions) and across cases (e.g. by HSOs and SSOs). These tables and resulting themes are presented in Chapter Four.

Synthesis of Findings

Initial findings from survey, network maps, and interview/document analysis were developed separately. The multiple streams of data from the qualitative and quantitative strands of this study were then compared and integrated during the final stage of the research when results were written for Chapter Four. Quantitative and

qualitative data were synthesized to develop a detailed description of each of the AHC case regions and their contexts, drawing from survey, network maps, interview and document analysis. Similarities and differences in structure and function within and across regions were noted. These case descriptions are presented in Chapter Four, followed by a discussion of themes related to the dimensions of the Appropriateness Framework (i.e. identity, perception, situation structure and decision rules) observed within sectors. Chapter Four also explores how these themes varied across the four AHC regions. This comparison and synthesis of findings informed the discussion and conclusions that are presented in Chapter Five. Qualitative and quantitative findings were synthesized in order to comprehensively discuss the four aims of this study (outlined at the beginning of this chapter).

Researcher Positionality and Protection of Human Subjects

The researcher adopted an intentionally critical perspective in this research – one that assumed differences exist in the relative power and resources of participating organizations within multi-sector partnerships (Kadushin, et al., 2005; Milbourne, 2018), and that many of these differences can be traced to racist, classist and otherwise exclusionary histories within Oregon and the United States (Lawson, Jarosz & Bonds, 2010; Goodling, Green & McClintock, 2015). The researcher assumed that the aspirational language of strategic alignment within multi-sector health partnerships may have masked ambivalence, skepticism or even resistance that individual participants felt toward working with one another. This study was designed with the intent to surface and

confidentially discuss some of these tensions with organizational representatives over the course of the research rather than leaving them unexplored.

The research process adhered to Portland State University's ethical standards for research involving human subjects and was supervised by a doctoral dissertation committee chair and a committee to ensure that the research proceeded in a manner consistent with these standards. The researcher obtained and maintained certification in Human Subjects Research from the Collaborative Institutional Training Initiative ("Human Subjects Research," 2015). All data collection methods and instruments used in this study were jointly submitted by the researcher and dissertation committee chair to the Portland State University Institutional Review Board for approval prior to use.

There were minor risks to the research participants of this study that were disclosed. The risks to interview participants related to the potential disclosure of personal, sensitive or proprietary information. To mitigate this risk, raw data were stored in password-protected ATLAS.ti and Kumu.io accounts accessible only to the researcher and dissertation committee chair. The identities of interview participants, their organizations and case regions were not disclosed in any presentation of findings. These risks and protections were described to interview participants in the initial invitation, reviewed during the interview scheduling process, and again at the beginning of all interviews. Interview participants were informed that participation was voluntary and that they could decline to answer any questions. Informed consent was obtained from all participants in the form of an electronically signed consent form (see Appendix C).

While the nature of the survey allowed for neither anonymity nor confidentiality of organizational identity, all information collected in the survey was of a public nature and minimally invasive. Survey data were stored in a password protected Qualtrics account that was only accessible by the researcher and dissertation committee chair. Information collected in the survey appeared in aggregated or de-identified form in the presentation of findings. This information was also provided to survey respondents and informed consent was obtained from them at the beginning of the survey, prior to collection of any responses (see Appendix E).

Conclusion

In summary, the intent of this research was to answer the question, “How are the organizational risks of strategic alignment perceived by health and social service leaders within communities for health?” This research was informed by the field of Critical Systems Heuristics (Ulrich & Reynolds, 2010) that aims to “unfold problems” by understanding how they are perceived from multiple perspectives and with explicit consideration for heterogeneity in the identities, positions and values of stakeholders. The four Accountable Health Communities regions in Oregon and their participating organizations served as diverse cases to explore the dimensions of Weber, Kopelman and Messick’s (2004) Appropriateness Framework, a conceptual model of how actors approach decision-making within collective action dilemmas.

The Appropriateness Framework’s dimensions of stakeholder identity, perception, task structure and decision rules were useful for comparing how organizational decision-makers perceived the organizational risks of strategic alignment within a community for

health. Surveys, network maps, key informant interviews with organizational decision makers, and document review were used to explore dimensions of the Appropriateness Framework within and across the four Accountable Health Community case regions in Oregon. These data were analyzed and synthesized to 1) present a detailed overview of the case networks, 2) present themes and key findings related to dimensions of the Appropriateness Framework, and 3) discuss the research question and four case study propositions in light of these findings. These results are presented in Chapter Four, with a comprehensive discussion of the research implications in Chapter Five.

Chapter Four – Results

Note: The study results presented in this Chapter are published in:

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Overview

As was introduced in previous chapters, this research explores health and social service organization leaders' perceptions of collaboration risk through the lens of Weber, Kopelman and Messick's Appropriateness Framework (2004). The Accountable Health Communities (AHC) project in Oregon was a valuable case study for exploring perceptions of risk in collaborations because it presented a well-defined group of health and social service organizations with an opportunity to collaborate within a social determinants of health (SDoH) screening and referral network. This allowed for the exploration of health and social service organization leaders' perceptions of future collaborations as well as existing or established partnerships.

This chapter presents findings from the research, including a detailed description of the AHC project and key similarities and differences in health and social service leaders' perspectives on multi-sector collaborations, explored through the lens of the Appropriateness Framework domains (Weber, Kopelman and Messick, 2004). This chapter then presents a detailed description of how the overarching themes varied across

the four AHC regions, in order to further examine how the Appropriateness Framework helps illuminate the perceived risks of collaborations across different contexts.

The term “participant” is used throughout this chapter to describe the people who participated in this research study. To clearly differentiate between references to the research participants and their program participants, the term “client” is used to describe people who were served by health and social service organizations. The author acknowledges that this term is not universally accepted. There was no single term consistently used by all research participants to describe the people served by their organizations. Other terms included “program participants,” “beneficiaries,” “patients” and “individuals.”

Case Description

The Centers for Medicare and Medicaid Services (CMS) announced in 2017 that the Oregon Rural Practice-based Research Network (ORPRN) would be one of the demonstration partners across the country participating in the Accountable Health Communities project (CMS, 2017). Oregon was the only west coast state to participate in the AHC project, and ORPRN was one of nineteen organizations that would participate in the ‘Alignment Track’ to encourage coordination among health and social service organizations (in contrast to the AHC ‘Assistance Track’ which focused exclusively on patient screening and referral activities) (CMS, 2017).

The AHC project was formally launched in Oregon in 2018, with ORPRN staff recruiting organizations in the four participating AHC regions (described in Chapter One, and below) to conduct client screenings for five health-related social needs, referrals and

navigation support. Initial plans for the project called for the screening of 75,000 Medicare and Medicaid-enrolled individuals once participating organizations were conducting screenings at full capacity. Within the scope of the Oregon AHC project, 2,000-3,000 individuals with at least one health related social need, who self-identified during screening as accessing the emergency department two or more times in the past 12 months were also eligible for additional navigation assistance from a trained staff member such as a community health worker. Staff would support the individual to access services for any unmet needs identified during the screening process and would aim to maintain communication with the individual until their social need was met (for up to 12 months).

CMS required that ORPRN, as one of its AHC awardees, use a standard screening tool that had been developed for the AHC project for assessing individuals' social needs. While CMS required the use of this screening tool, CMS gave its awardees flexibility to determine the data platform they would use for collecting and managing screening and referral data; awardees could use a data platform developed by CMS, or alternately, develop their own data management system. One of the primary advantages for awardees in developing their own data system was that they would retain access to the system after the AHC demonstration had ended, whereas those awardees using the CMS platform had no guarantee that it would be available after the grant period ended.

ORPRN opted to use its own system and contracted with an Oregon-based software vendor, Vista Logic, whose care coordination platform, Clara, was already in use by other SDoH screening and referral projects in Oregon such as Bridges to Health

and Community Pathways Network (211info, 2019). The platform had been developed to integrate with 211info's information and referral database that contained statewide data on social service programs (211info, 2019). This database integration allowed for participating organizations to enter AHC screening data for an individual into Clara and then generate a list of relevant social service programs in the individual's geographic area of residence. The database also served as a care coordination hub for patients receiving additional navigation support through the AHC project. The database stored care coordination records and accumulated screening data over time to be reported by ORPRN to CMS, as well as back to the AHC screening organizations.

The ORPRN team recruited organizations to participate in AHC screening in early 2018. Contracts were negotiated at that time estimating the number of individuals each participating organization intended to screen and for whom they would be reimbursed. Initial trainings were conducted with site staff to introduce the screening and referral protocol and the database. However, similar to several other AHC sites across the country, the Oregon AHC project encountered a substantial delay when technical difficulties prevented the local database from communicating with the CMS database for reporting purposes. Between autumn 2018 and spring 2019, AHC project implementation paused while these technical difficulties were addressed. Screening commenced in April 2019, and while all of the originally contracted organizations opted to continue with the project, additional retraining was required due to the lapse in time since participating organizations' initial orientation. The screening process thus ramped up through the late spring and summer of 2019. Participant recruitment and data collection for this research

study occurred from April to August 2019, when contracted organizations had just begun conducting AHC screenings, referrals and navigation support.

Research Participants

As described in Chapter Three, nine health service organizations (HSOs) were recruited for this study from the organizations contracted with ORPRN across the four Accountable Health Communities regions: the Rogue Valley, Central Oregon, Columbia Gorge and Yamhill Valley. These nine HSOs recruited for this research reflected a diverse range of health programs and services, including Federally Qualified Health Centers (FQHCs), non-FQHC primary care and/or wellness clinics, public health departments, a dental care clinic, a Coordinated Care Organization and a patient navigator program (see Table 4.1). At the time of this research, all nine recruited HSOs had participated in initial AHC project training with ORPRN and had begun screening efforts.

Table 4.1: Participating Organizations

By Organization Type		By Region
Health Service Organizations (n=9)	Social Service Organizations (n=13)	Region A (n=6)
<ul style="list-style-type: none"> Federally Qualified Health Centers (2) Primary Care Organizations and Clinics (non-FQHC) (2) Public Health Departments (2) Dental Care Organization (1) Coordinated Care Organization* (1) Patient Navigator Program (1) 	<ul style="list-style-type: none"> Senior and Disabled Services (3) Housing Authorities (2) Community Action Agencies (2) Emergency Food Relief (2) Immigrant and Refugee Programs (2) Domestic Violence / Sexual Assault Programs (1) Housing Case Management (1) 	<ul style="list-style-type: none"> Health services (3) Social services (3)
		Region B (n=6)
		<ul style="list-style-type: none"> Health services (2) Social services (4)
		Region C (n=5)
		<ul style="list-style-type: none"> Health services (2) Social services (3)
		Region D (n=5)
		<ul style="list-style-type: none"> Health services (2) Social services (3)

Note: The four case regions are de-identified and referenced as Regions A, B, C or D to protect participants' confidentiality. Identifying regions by name could result in the re-identification of specific organizations in those regions.

Social service organizations (SSOs) were identified for this study through a review of the community resource lists that had been provided to AHC-screened individuals; these lists were stored in the AHC data management system. From these lists, SSOs were selected for recruitment on the basis of region and resource type in order to achieve a sample that included three to four SSOs per AHC region, and at least two organizations providing services in each of the AHC resource categories (food, housing, transportation, utility assistance and safety/violence prevention). This approach resulted in the recruitment of 13 SSOs from the Yamhill Valley, Columbia Gorge, Central Oregon regions, and Rogue Valley region. They reflected a range of organization types including both private nonprofit organizations such as emergency food pantries and social work programs, and quasi-governmental organizations such as Area Agencies on Aging, Housing Authorities, and Community Action Agencies (see Table 4.1).

As was described in previous chapters, the organizations recruited for this research (n=22) were asked to identify an individual to participate in the research who occupied a leadership role and exercised decision making authority over the organization's community partnerships. All organizational leaders (n=23, 100%) completed a semi-structured interview with the researcher; one organization opted to have a second individual jointly participate in an interview, as the primary participant was new in her role (see Appendix F for interview protocol and Chapter Three for a description of methods). Eight of nine HSO leaders (89%) and 12 of 13 SSO leaders

(92%) also completed a survey to collect information about organizational characteristics, partnership and collaborative activities for this study (see Appendix D for survey instrument). These samples of organizations and leaders are not large nor intended to be statistically representative of the broader health or social service sectors or the AHC geographic regions as a whole; however, as will be discussed, these survey responses provided additional context for the themes that emerged when participant organizations were segmented by health and social service organization type (i.e. “by sector”) or by AHC region.

Organizational Characteristics

Survey responses revealed certain similarities and differences between the organizational characteristics and partnership activities of the HSO and SSO participants in this study. The HSOs that participated in this study were larger by budget size than the SSO participants. While 63% (n=5) of responding HSOs had an operating budget of \$5 million per year or more, fewer than 17% of SSOs did (n=2) (see Figure 4.1).

Figure 4.1: Organization Budget Size, by Sector

This may have been related to another observed difference: HSOs in this study tended to work across a wider service area than their SSO counterparts. HSO respondents reported working in an average of 3.25 of the AHC counties (out of nine possible) compared with an average of 2.09 counties for SSOs (see Figure 4.2).

Figure 4.2: Counties Served by Participant Organizations, by Sector

While HSOs each had a primary identity (for example, health department, primary care clinic, etc.), survey responses indicated a range of services provided by HSOs, with physical health and/or public health services the most commonly reported (n=4 each, 50%), followed by behavioral and/or oral health services (n=3 each, 38%). The least commonly reported services provided by HSOs were substance use disorder (SUD) treatment; housing, food, or utility assistance; and/or domestic violence intervention (n=2 each, 25%) (see Figure 4.3). Notably, half of the responding HSOs reported being involved in the direct provision of at least one service traditionally associated with social service organizations (i.e. housing, food, transportation or domestic violence intervention).

SSO leaders' survey responses indicated that food assistance was the most commonly reported type of service (n=7, 58%) followed by housing assistance (n=6, 50%). "Other services" reported by seven out of 12 SSOs (58%) included early childhood and childcare programs, home weatherization, sex trafficking intervention, financial services and education, legal aid, peer support services, in-home and respite care, and health insurance enrollment assistance. Physical and oral health services and SUD

treatment were not provided by any participating SSOs, and behavioral health services were provided by only one SSO, suggesting somewhat less crossover in services among SSOs than was seen among the HSOs (see Figure 4.3).

Figure 4.3 Services Provided by Participant Organizations, by Sector

Collaborative Activities

In survey responses, HSO and SSO leaders reported a variety of ways in which their organizations collaborated with other organizations to provide services, including both community and system-level collaborations that took the form of participation in multi-sector meetings and planning processes, as well as direct collaborations with organizations from other sectors. While there were overarching similarities in the types of collaborations or partnership efforts described, differences emerged within these categories as to how HSO and SSO leaders described their efforts. These are explored below.

Seven of eight responding HSOs (88%) reported that they were engaged in other community-level multi-sector partnerships to address social determinants of health (SDOH) beyond the AHC project, while the remaining respondent (n=1, 13%) was planning to do so in the next 12 months (see Figure 4.4). Examples of these multi-sector partnerships included other SDoH screening and referral projects; partnerships for pregnant and parenting students or for opioid education; school-based health services; and partnerships to provide Medication Assisted Treatment (MAT) for opioid use disorder in jails.

Figure 4.4: Collaboration Activity, by Sector

Slightly more than half of the responding SSOs (n=7, 58%) reported they were currently participating in community-level multi-sector partnerships; examples provided included regional health councils, regional councils of government, early learning hubs, and Coordinated Care Organization (CCO) Community Advisory Councils; other SDoH screening and referral projects; housing wraparound initiatives focused on frequent emergency department utilizers; joint case management groups including county-level multi-disciplinary teams for child abuse prevention; and coordinated universal screening initiatives for child development. No SSOs reported that they were planning to enter into a new multi-sector partnership in the next 12 months, and the remaining SSO respondents

(n=5, 42%) reported they did not know whether their organization would participate in any multi-sector partnerships in the next year (see Figure 4.5).

Figure 4.5: Current Collaborations to Provide Services, by Sector

HSO leaders also reported a variety of direct inter-organizational collaborations. Among HSOs, current collaboration with organizations providing physical health and/or transportation services were most common (n=7 each, 88%), while collaboration was less common with organizations providing utility assistance (n=4, 50%), oral health (n=5, 63%), housing (n=5, 63%) or domestic violence intervention (n=5, 63%) (see Figure 4.5). Two HSOs (25%) reported planned collaborations in the next 12 months with partners providing either housing or oral health services (see Figure 4.6).

Among responding SSOs, the most commonly reported current collaborations were with organizations providing physical health, behavioral health or food assistance

(n=8 each, or 67%) (see Figure 4.5). SSO collaborations with organizations providing oral health services (n=4, 33%) and substance use disorder treatment (n=3, 25%) were the least common. Two SSOs (17% each) reported planned collaborations in the next 12 months with organizations providing substance use disorder treatment (see Figure 4.6).

Figure 4.6: Planned / Future Collaborations in the Next 12 months, by Sector

In summary, survey responses indicated differences in HSO and SSO participants' organizational characteristics. HSO organizations were generally of larger size (by budget) and worked across more counties than their SSO peers. HSOs more often reported "crossover" services (i.e. provision of some services typically identified with the social sector) while fewer SSOs reported providing services typically identified with the health sector. There were also differences in collaborative activities. HSOs more often reported participating in community-level multi-sector efforts than their SSO peers and those that did so gave examples of initiatives to serve specific populations or target

specific needs in the community. In contrast, the examples of community-level cross-sector efforts given by SSO leaders tended to be community meetings, advisory committees or planning processes rather than initiatives serving specific populations or addressing specific needs. Both HSO and SSO leaders commonly reported partnering with other organizations that provided physical health or transportation services, and less frequently reported partnering with organizations providing oral health and utility assistance.

The organizational context in which HSO and SSO leaders operate may be an important factor in how they perceive risk in multi-sector partnerships (as reviewed in Chapter Two). In addition to providing useful information to inform the interviews that were conducted for this study, these survey responses also revealed that baseline differences existed in these organizations' characteristics and collaborative activities. The way in which these factors may have contributed to their leaders' risk perceptions in collaboration with one another is further explored below through the themes that emerged from participant interviews.

Themes by Sector

As introduced in previous chapters, qualitative data (interviews and documents) were thematically analyzed using a conceptual framework for decision making in collective action dilemmas. This conceptual framework delineated three domains of decision making -- identity (i.e., "what kind of people are we?"), perception of the situation (i.e., "what kind of situation is this?"), and task structure (i.e., "what are my options and constraints?") – that interact to shape the heuristics or cognitive rules that

guide leaders' decisions to compete or collaborate (i.e., "what does a person like me do in a situation like this?"). The process of thematically analyzing qualitative data for this study involved the use of a coding schema developed from these domains and related constructs in order to explore similarities and differences in HSO and SSO leadership decision making about multi-sector collaboration.

The similarities and differences in HSO and SSO themes are described in further detail below, organized by the framework domains. This analysis emphasizes cross-cutting similarities and differences that emerged among organizations when they were grouped by health and social service sectors. However, meaningful differences also exist within sectors, and what is generally true of the group as a whole is not always true of each individual organization or participant within the group. In-depth exploration of these within-sector variations is beyond the scope of this research, though major deviations from within-group themes are noted where they occurred.

Identity

The Appropriateness Framework (Weber, Kopelman and Messick, 2004) suggests that identity is an important dimension of decision making within collective action dilemmas because it shapes the merits of various goals, and the acceptability of various actions, according to one's values and sense of purpose. Participants self-identified as holding leadership positions within their organizations, but their roles reflected a range of titles and duties such as Executive Director, Program Director, Clinic Manager or Director, Public Health Director, etc. Interviews revealed differences between HSO and SSO leaders' personal motives, values and histories, and organizational purposes and

histories. While there were similarities in the types of stakeholders described by HSO and SSO leaders, there were also key differences in how leaders described their responsibilities to these stakeholders.

Personal Motives. HSO leaders reported fairly long tenures with their organizations, often five or more years. This contrasted somewhat with SSO leaders' histories, which reflected more of a mix of individuals who had been in their roles for five or more years and others who were relatively new to their organization. HSO leaders described a mix of clinical (including nursing and mental health) and nonclinical backgrounds (such as human resources, information systems, etc.), but none had previously worked in social services organizations. These quotes illustrate how some HSO participants described their backgrounds:

I started out very early in my career working in the substance use disorder treatment facilities as a behaviorist. I have bachelor's degrees in psychology and forensic science, so I kind of stumbled into this role managing projects and program development as well as being a health and wellness consultant. [Primary Care Clinic leader]

My background is in nursing. I've been with [organization] since the early days, so my role has evolved. [Coordinated Care Organization leader]

I started out as a health education teacher when I was a school nurse and I was working on a master's in school administration. Life changes happen, and I ended up going to public health. [Public Health Department leader]

My background is in information systems. I spent 20 years doing that, and then I changed jobs right after Y2K. [Primary Care Clinic leader]

This contrasted with SSO leaders, several of whom had begun their careers in health services or public health, and later moved into roles with social service agencies. SSO leaders possessed varied backgrounds including several who had formal social work

training, and others whose training was in law, education, or religious studies, as these quotes illustrate:

When we moved to this area, I did alcohol and tobacco prevention services for the county, and a lot of different county [roles] that didn't need a nursing license. When I saw that [SSO] had some job openings, I had a really big interest in that, so I started here ... and now I oversee all of our programs. [Community Action Agency Director]

When I was nineteen, I started working in a memory care unit. I never thought that I would continue working in geriatrics. That's just where I landed, and I found a passion for it. So, I went back to school and got my bachelor's and then ultimately my master's in social work. [Area Agency on Aging Director]

I have a doctorate in behavioral therapy and worked as executive director of another nonprofit and now director of this department. [Social Services Department Director]

I attended law school when I was pretty young. I was in a nonprofit law practicum where I tried to learn a lot about the housing world. I decided that's what I wanted to do. I wanted to change careers. [Housing Authority Manager]

Being of service to others and doing meaningful work were evident motivators among both HSO and SSO leaders, as were concepts of efficiency and focusing on results. Both groups also emphasized values of fairness, sharing power, and dignity for people served through their organization's work. For example:

I've always had a passion for serving the underserved. [HSO leader]

I love networking and trying to get the right people in the room to problem solve. [HSO leader]

I've always worked with people that were living in low income situations. So that's just a population that I'm really drawn to. [SSO leader]

I didn't necessarily have language for trauma or other things that these families might be going through, but I knew there was more that I wanted to do [for them]. [SSO leader]

There were also differences in the personal values espoused by individuals within the two groups that related to their approach to their work. For example, HSO leaders sometimes spoke of the importance of having clear boundaries between one's personal and professional life, while SSO leaders emphasized the importance of doing work one is passionate about and aiming to "say yes" when opportunities arise to be of service to others. For example:

Literally nothing keeps me up at night. That's my policy. I leave work here. I don't think about it. [HSO leader]

I think as a leader, it's my [modus operandi] to say yes to these kinds of things. So that's probably a bias I have, and maybe my role requires me to have that bias. [SSO leader]

This difference was also evident in how HSO and SSO leaders described the centrality of their work within the context of their lives. While very few HSO leaders talked about relocating for their jobs at any point in the past, SSO often did so, as these quotes illustrate:

[The organization] wanted me and all of the directors to move to [another city] and I did not want to do that. I knew we were recruiting for [this] role in [city], so I changed career paths into public health and here I am five years later. [HSO Director]

Before here, I was in [another state]. I was a minister there. I also did a lot of youth programs. It was just recently that they gave me a call and they're like, "hey, we're moving you to [Oregon]." [SSO Director]

Organizational Motives. With respect to their organizational motives for working on SDoH, HSO leaders emphasized the importance of taking a systems perspective by understanding people holistically, within the full context of their lives.

Some framed their work explicitly in terms of “health systems transformation” or moving along the path toward “population health management” as these quotes illustrate:

I think at a clinic level, [the AHC project] definitely reframed my view of leadership around population health. [HSO leader]

We have a population health team that's doing a lot of our strategic planning. One potential benefit [of the AHC project] is to use that data to help inform the way that we are identifying [individuals with unmet social needs] that we serve and to also inform where the biggest gaps are. [HSO leader]

We're really trying to take a strategic approach to see what we can do to help our CCO partners with social determinants, health screenings and referrals to appropriate resources. We primarily see low income folks who are most adversely affected by social determinants of health factors. [HSO leader]

SSO leaders typically framed their organization’s work in terms of specific populations of people (such as immigrants and refugees, children, or seniors), rather than systems or services. Similar to HSO leaders, they also described the need for a systems perspective when working with clients, but more often described working to help clients understand how to navigate systems, as these quotes illustrate:

We work to connect folks living with no or limited income to the resources they seek ... We sit with folks and do the work together because I want them to learn what their rights are, how to self-advocate and where the resources are, so they can do that independently and not have to come to me every time they don't have money for their utility bill. [SSO leader]

Part of our work is community education. We consider that an essential part of our work, to do know-your-rights presentations. [SSO leader]

We do a variety thing of things under the umbrella of keeping children safe and families together. [SSO leader]

There was some contrast in perceptions of their organizations’ history of success in working collaboratively on SDoH. HSO leaders frequently described that their

organizations had already been “doing the work” of AHC in a less formal way, and that they had a history of successful partnerships and collaborations with other organizations in their region. These participants stated:

Without even having the AHC project, we were sort of doing this work anyway.
[HSO leader]

I think for AHC, we were already doing the work. We just didn't have a structured process of how to do it, or support through technology, or thinking about how this could be incentivized to sustain it. [HSO leader]

SSO leaders expressed more ambivalence about past efforts. Some described collaborations with HSOs positively while others described how changes in Oregon's health sector had unintended consequences for the social sector, as these quotes demonstrate:

It was a natural tie-in that as CCOs were developing regionally, there would be a connection [to social services] because many CCO members are seniors or disabled adults. [SSO leader]

This year we had a huge problem with [HSO]. They had a large provider group that dropped out of contract during open enrollment. Then there was tons and tons of communication back and forth between them. “We have a deal. We don't have a deal.” “We're in your network. We're not in your network.” It really threw a vulnerable population of seniors into a very frightened and scared place, not knowing what their [health] coverage was going to look like. So, at that time, our relationship with providers was pretty rough. It didn't feel like they were owning a piece of the accountability that they should have owned, and that was coming back onto our little volunteer program, where we have five volunteers serving 5,000 clients. [SSO leader]

At the same time, both HSO and SSO leaders sometimes reported that successful collaborations had not been sustained, often due to the end of funding, as these quotes illustrate:

We had, together with a few other stakeholders, funded a community engagement coordinator, which was hugely impactful because she was constantly updating local information. We were just starting to build the trust around the viability of the resources [lists] that were produced and then her funding ended. [HSO leader]

We had a co-located mental health provider at a rural health clinic for a long time. Then that clinic closed. [SSO leader]

I used to have a community health worker stationed here. That was hugely impactful for my consumers. When the health department decided not to do it anymore, I got 48 hours' notice that I was losing my health worker. [SSO leader]

Stakeholders and Responsibilities. Both SSO and HSO leaders emphasized the importance of relationship building in pursuing their organization's goals, describing networking, mentoring, and working across disciplines as key elements of their work. When describing their organizational stakeholders, HSO and SSO leaders described their responsibilities differently with regard to their clients, their organization, community partners and the community at large.

With regard to clients, both HSO and SSO leaders emphasized their desire to be a "one stop shop" for the people they served, providing as many services as possible and reducing the need for clients to be referred away for other services, as these quotes demonstrate:

That whole concept of "wraparound" or "one stop shop" or "no wrong door" is so beneficial to those that it's serving. [SSO leader]

Our objective is always about trying to do the best job we can for the patients here in town if at all possible and not feel like they've got to go somewhere else. [HSO leader]

A key difference was apparent between HSO and SSO perspectives with respect to clients' autonomy, with SSO leaders emphasizing the need to present clients with

multiple choices or options whenever possible, and respecting their right to determine what actions to take. SSO leaders described clients as holding the power to determine what changes would constitute an improvement in their situation, as these quotes illustrate:

Clients have to have options, because you don't want to be seen as wanting clients to only go to a certain location. We don't want to open the door for any assumptions. [SSO leader]

One of the things I like about my job is that I don't necessarily get to have a strategy, in the sense that I work for my clients ... My job is to lay out "here are your options" and then do what they choose to do, even if it's not my first choice. And that happens frequently. [SSO leader]

In contrast, HSO leaders appeared to more often hold their own opinions about what changes would constitute an improvement in a client's situation, and these improvements were expressed in terms of health outcomes. While their duty to clients included obtaining feedback and incorporating individual perspectives into decision making, their principal responsibility was to improve an individual's wellbeing or situation, as these quotes demonstrate:

We feel that [AHC] is a benefit for the clients; that it's another way of talking to them and getting information from them about their circumstances and their needs. It's just a little bit more invasive. The questions are much more direct, whereas the home visiting nurses are normally more conversation-driven and the client drives that conversation, whereas [AHC] is more direct. [HSO leader]

I see how much mental health, addiction and social determinants impact the ability to move or not move a chronic condition, a medical outcome. I hear the frustration in my providers' voices all the time about 'these noncompliant patients...' and it really has everything to do with the lack of resources and support that people have. Not that they're not compliant. [HSO leader]

Stated another way, HSO leaders tended to frame their responsibility to clients as identifying ways to improve their health status and taking actions accordingly, while SSO leaders described their responsibility as presenting options the client could take to improve their status, but refraining from any actions that may influence a client's decision. As will be further discussed in Chapter Five, this difference in leaders' orientations toward clients may reflect differing social norms within the health and social sectors, as well as the heavier reliance on outcome measures and quantified indicators of performance within the health sector. These different orientations to client autonomy were sometimes described by SSO leaders as a source of conflict between health and social services, as these quotes from SSO leaders demonstrate:

In food banking we have tried to give people more choice. We've tried to be more dignified. So, [HSO] wanted me to have a list of foods to put behind the counter and insist that people have to ask for them, and then maybe they won't choose them. It's not just sodas and chips. It's canned entrees, sugary cereals, pop tarts. There's a whole list of things they'd love to see behind the counter. Number one, food pantry volunteers don't have time for that. Number two, it is totally counter to us saying "people should have choice." [SSO leader]

We don't want [clients] to be targeted or pushed to do a certain thing. [A partnership] has to be something that's neutral and benefits the client, nothing that's going to require them to apply or use a certain service. It can't be building a business for somebody else. [SSO leader]

In addition to their responsibilities to clients, HSO and SSO leaders both described responsibilities to their organizations. In HSOs, this responsibility was expressed through accountability to staff, including obtaining staff buy-in on new activities, being mindful of the impact of new activities on staff workloads, and retaining staff. In multi-site HSOs, this also manifested as needing to honor the individual

leadership styles and team cultures of each site where an initiative such as AHC would be implemented, balancing the priorities of senior leadership with the priorities of mid-level managers and front-line staff, as these quotes demonstrate:

There are so many competing priorities, and we're working with such a vulnerable population, that it can be really difficult to keep employees motivated and engaged when you're sort of continually asking for one more thing, one more thing, one more thing. [HSO leader]

We can't make those decisions. We have to involve the clinic managers, and there's a different manager for every clinic. [HSO leader]

Among SSO leaders, the responsibility to the organization was expressed through being able to justify the decisions and actions of leadership and behaving in ways that were consistent or aligned with the organization's mission. For example, these SSO leaders stated:

The measure should be the mission. So, if we say we keep children safe and the families together, then that should be the measure of success. [SSO leader]

We're the only provider of domestic violence, sexual assault, stalking and sex trafficking [services] in our county. That's our lane, and that's where we stay. [SSO leader]

For SSO leaders, there was less emphasis on staff workloads or retention than was seen in HSOs, but a greater emphasis on the obligation to find and secure resources that could sustain staff positions over time. As will be discussed in Chapter Five, this may point to differences in organizational context and resource dependencies within health and social services that make SSO leaders more highly attuned to the financial implications of collaboration. For example:

Part of the motivation [to collaborate] is financial. We need to figure out better, more sustainable routes of funding. Right now, we're primarily grant funded and that's a tough way to fund a nonprofit. [SSO leader]

Both HSO and SSO leaders described professional obligations to the community at large. Within HSOs, there was a strong emphasis on the obligation to align their services with regional priorities and gaps. In SSOs, this was more often expressed as the obligation to raise awareness of the needs of underserved populations that the organization may represent or serve, ensuring that their issues and needs were advocated for within community conversations. These quotes illustrate this difference:

One of the things we focus on is our regional health improvement plan. A lot of the [AHC] goals are also part of our regional health improvement plan. So, people have shared goals [through the plan]. [HSO leader]

The benefit of partnering is bringing aging [issues] to the table and [getting the community to] recognize that we need systems and services in place to address the huge influx in older individuals in our area. We don't want to lose aging as part of the conversation. [SSO leader]

Responsibilities to community partners were also described differently by HSO and SSO leaders. Within HSOs, accountability to community partners was often described as following through on one's commitments and being a mentor to others. Two HSO participants stated:

The other piece [we consider] is whether [a collaboration] fits within our philosophy. Is it conflicting with other commitments that we've made to any other organization? [HSO leader]

We're a rural health educator, so we're very committed to that perspective. It's part of our core values, what we believe in, and what we do every day. [HSO leader]

SSO leaders described their responsibility to community partners as signaling support for others' work, avoiding behaviors that could be perceived as competitive, and

making efforts to “be connected” with as many partners as possible, as the quotes below illustrate. Notably, these perspectives reflect how SSO leaders felt they should act toward others in the community, but this does not mean they always described their actions as adhering to these obligations (particularly with respect to competition for resources):

We are known in our community for supporting other nonprofits. When possible with our larger grants, we [support] a lot of subrecipients. [SSO leader]

We try to have conversations with as many different community partners as we can. We're trying to get our feelers in all kinds of different avenues that we might not currently have. [SSO leader]

In the specific context of current or potential funders (particularly Coordinated Care Organizations), both HSO and SSO leaders described an obligation to “keep them happy” and align with their priorities. For example:

You always want to have the blessing of the payer. So if we're able to fulfill a strategic priority for them and for ourselves, you always look for that overlap. [SSO leader]

If the CCO comes knocking, you answer that door and ask how high [to jump]. [SSO leader]

A lot of our goals are aligned with our CCO partner's goals. If health equity and social determinants of health are their goals, we want to make sure that we're doing our part to help our CCO partners reach their goals. [HSO leader]

In summary, there were both similarities and differences observed in how HSO and SSO leaders described their personal and organizational motives for multi-sector collaborations. Personal values such as being of service, and promoting fairness and dignity, were commonly described as motivators by both HSO and SSO leaders, though HSO leaders placed greater emphasis on maintaining balance between their professional and personal lives. In describing their organizational motives to collaborate across

sectors, HSO leaders often framed their efforts in the context of broad health system transformation efforts (which they perceived themselves to be supporting); in contrast, SSO leaders often described helping clients to understand and navigate systems as they currently existed (rather than being engaged in sector-wide change initiatives).

These differences were also apparent through how organizational leaders described their responsibilities and obligations to their clients, their staff and other internal stakeholders, and the community at large. HSO leaders more often described the responsibility to support regional or national goals for population health improvement, while preventing burnout or turnover among staff. SSO leaders emphasized the responsibility to take actions consistent with the organization's mission and ensure that priority issues or populations were represented in community conversations (which included, by extension, a responsibility to raise resources to sustain these activities). As will be discussed further in Chapter Five, these differences in HSO and SSO leaders' perceived responsibilities to clients, staff and the community suggest differences in resource dependencies and social construction of client populations across the health and social sectors.

Perception of the Situation

The Appropriateness Framework suggests that the perception of a situation is an important element of decision making within collective action dilemmas (Weber, Kopelman and Messick, 2004). Individuals may have different perceptions of "the problem" they are trying to overcome through collaborations and their assessment of potential outcomes (i.e., which options may represent an improvement over the status

quo, and which would represent a loss or worsening of the situation). The similarities and differences in how HSO and SSO leaders described the problem to be solved by projects such as AHC, and the value of potential outcomes, are described below.

Changing Social Context. Interviews revealed that there were both similarities and differences in how HSO and SSO leaders understood the problems that multi-sector health partnerships were meant to address. Some HSO and SSO leaders described multi-sector partnerships as necessary to help organizations overcome deeply entrenched social issues, such as economic inequality or intergenerational poverty, that they were struggling to respond to and could not address on their own. Both HSO and SSO leaders also cited social, demographic and economic changes in their communities that would require collective responses from organizations, as these participants described:

Our economy is changing. Our social influences are changing. We have to be open to seeing other ways to work together, to address needs that are different than before. [SSO leader]

With the growing homeless crisis, we're seeing more need to make sure people are accessing services, to prevent either child abuse or bigger crises down the line. [HSO leader]

A lot of baby boomers don't have spouses or children, so how do we as a community come together and recognize that we're going to have all of these people who might not have access to the natural [family] support that we once had? [SSO leader]

This opioid crisis has exacerbated the problem. A lot of our [patient] dismissals have been around drug related issues. Some patients started getting weaned back and acted out in ways that led us to be concerned about the safety of our other patients and staff, to the point of where we said, "you can't come around here anymore." [HSO leader]

Lack of Visibility or Understanding Across Sectors. Both groups spoke frequently of the problem of the health and human service sectors operating in “siloes,” and both groups described multi-sector partnerships as a way to overcome “being siloed.” The near ubiquity of this perspective about being siloed was noteworthy, as it sometimes appeared to reflect an ideology rather than a specific experience, as these quotes demonstrate:

We're all very siloed, but I think that's why we're really hungry to get together.
[HSO leader]

Everything has just been so siloed for so long. [SSO leader]

Different nonprofit agencies and health care agencies just don't talk to each other. I think we have a lot to learn from each other. [HSO leader]

Although it may not be thought about much in the [context] of siloing amongst the types of services that are offered, we really are in need of expansion of understanding so that we can all help people be healthier, in a holistic way. [SSO leader]

When prompted for what “being siloed” meant to participants in the context of their daily work, HSO and SSO participants alike described that their services, programs, or priority issues were not visible to, or well understood by, their community, as these quotes illustrate:

Hopefully [other organizations] will be using word of mouth to let other people know that we're here and that we have programs that can help people in lots of different ways, because I don't think most people have a clue what we do. [HSO leader]

One of the difficulties for us, even in as many decades as this department has existed, is there are so many people in the community that have no idea there is this support system in place that is available to them as community members.
[SSO leader]

Participants commonly expressed a desire to be more visible or understood by other HSO and SSO professionals; this desire manifested within both groups as wanting to connect or collaborate, including through projects such as AHC. For example:

That's a great part about being involved in [a referral program], is teaching other agencies about all of the work that we do. [SSO leader]

I think as a result of AHC and our participation in it, it, it gave more visibility to [our organization]. [HSO leader]

I look at our partners as ambassadors to help educate potential persons to be served through the referral sheets and the discharge planners we hand out that list all of our programs. For them to be ambassadors extends our ability to be out in the community, speaking in public settings to help people become more aware. [SSO leader]

Part of what [collaboration] does for us that's a benefit is it just helps increase knowledge of us in the community. It gets our face out there more. [SSO leader]

Addressing Gaps versus Duplication in Services. While leaders in both sectors described the need for constant monitoring of available resources and re-development of new connections or referral pathways among programs, there were differences in how sectors perceived this challenge. HSO leaders tended to focus on the need to identify and address gaps in community services, while SSOs emphasized duplication and streamlining of existing services. HSO leaders saw collaborative projects as a way to more concretely assess resource needs in the community through data collection. For example:

I went looking for how we could use data to inform how we apply our limited resources [to social determinants of health]. [HSO leader]

You want to have enough data so that you could drive that up the chain and say, "we have this many patients with housing issues." You want a good cross section of your population to be able to voice that concern. [HSO leader]

Part of the learning we're hoping to get out of [AHC] is what resources are missing. That will be a good outcome, if it shows us that, and then it's up to us as a community clearly to act on those shortages and try to overcome them. [HSO leader]

SSOs more often described the redundancy that they perceived in programs and services. Some SSO leaders expressed frustration at the perceived instability of community programs that were discontinued due to lost funding and new programs that began in their place, led by other organizations. This instability in community programs was described as harmful to clients, requiring individuals to apply to multiple SSOs for the same types of assistance, or causing a cycle of individuals gaining and losing eligibility for assistance. These participants stated:

We saw a lot of people that were repeats. They get on the housing choice voucher. They lose their voucher, and then they get back on and off, on and off, on and off. [SSO leader]

The resources are always changing. It's hard for us to keep up and all we do is resources. We spend a lot of time trying to make sure that the information we're sharing and the connections we're making are up to date and accurate. [SSO leader]

One family can be getting resources from us and then they go to [another food pantry] and they're getting the exact same help that they received here. So, we're seeing a lot of duplicates. That's why we have the screenings. If we catch [duplication], we're able to sit down with them and be like, "Is everything okay? How can we help you further?" [SSO leader]

There was also a concern among SSO leaders that health systems were each developing their own approaches to screening and referring individuals for unmet social needs, with the risk that clients would receive redundant screenings and/or referrals across multiple locations. Some SSO participants stated:

I'm sitting on these boards and realizing that there are so many similar conversations happening. If we could just connect the dots, we would be able to have this huge, powerful conversation together, and then hopefully be able to move change forward. [SSO leader]

[The screening and referral networks] seem to be layered on top of each other. I don't know why [the HSOs] can't just settle on something. It seems to me like they can't come to agreement, and everybody's wanting to track everybody else. [SSO leader]

HSO and SSO leaders alike described the capacity of social service programs as the limiting factor in the efficacy of screening and referral networks and noted that social issues such as homelessness in their communities were worsening and becoming harder to respond to with existing program capacity, as these quotes illustrate:

Our outreach workers really struggle. Asking questions is one thing. Actually finding a resource rather than just helping [to] get people on a wait list is next to impossible. [HSO leader]

One of the big risks is over promising. We struggle with that a lot, that [other organizations] over-promise like, "oh, you have a housing problem. We'll just call up [organization]" as if there was a bunch of affordable housing just waiting for a phone call. [SSO leader]

One of the outreach workers is working with a woman who doesn't have enough money to pay her utility bill. The resource is once a year. Well, just giving someone money to pay their utility bill [once a year] doesn't solve the problem when that same person needs help to pay their utility bill again every month." [HSO leader]

Measuring Needs versus Meeting Needs. Some HSO leaders expressed skepticism about screening and referral networks as an approach to addressing social determinants of health, hoping that the AHC project would generate data on unmet community needs, but doubting that it would do much to address individual needs. Some HSO leaders worried that the AHC project may result in unreliable or incorrect resource

referrals or poor quality navigation support. Those that saw value in the screening process itself described how it held health service professionals accountable for having difficult conversations they might otherwise shy away from, and had potential to improve client trust in the accuracy or utility of referrals made, as these quotes illustrate:

It's giving space for health providers to ask questions around people's lives that they may not necessarily open up [about] in the doctor's office -- like housing, transportation, social needs. [HSO leader]

Some of those questions are pretty personal, and clients are going to tell that information to someone who they trust. And it might not be us, it might be somebody else. We're always reaching out trying to make sure that our referrals actually go someplace. [HSO leader]

Undoubtedly people are going to hit a roadblock accessing various services if they get the wrong person on the phone or it doesn't work out. That can be frustrating for the nurses that are doing the surveys, because they are the ones that are hearing back from the client, "Hey, that didn't even work." [HSO leader]

SSO leaders also expressed some skepticism about screening and referral processes in general for meeting clients' resource needs, and some felt that referrals were only likely to be effective when they were paired with support or case management. For example:

It doesn't work if it's just a referral. The community health workers tell me it doesn't work because they sit with someone in the 12 minutes they have and say: "here's a flyer for [agency]. Here's 20 different walk-in times you can attend. Go see them and they can help you." The person says "okay," but then we never hear from them, and then six months later that community health worker maybe connects with them again and says: "What happened with [agency]?" And they say, who?" [SSO leader]

We can hand out phone numbers and connect people as much as we want, but capacity and all these different factors come into play. If there was an ability to provide somebody with a navigator to walk through all of these things, it might be more beneficial. We get calls about that a lot, like "It's just me. I don't have

anyone here" and they really just don't have the ability to navigate all the different systems or phone calls or referrals. [SSO leader]

One SSO leader described referrals as a way for a person to feel as if they were “doing something” in the face of deeply entrenched social issues that health and social service workers alike felt helpless to resolve:

The people working at [HSO] making the referrals don't have any power to address the underlying issues. They are desperate to see their community's needs met, and they also can't make that happen, so referrals are a way to do something. If somebody tells you "me and my three kids are going to be out on the street tomorrow," that's not easy to walk away from as a human being. The individual doesn't have any power to address the housing crisis in America, so they're like, "well, I can give you a referral." I do the same thing, because I don't want to just walk away like "Wow, that sucks. I'm sorry." That feels terrible, so people look to a referral system. The people who are on the front lines, that's their option. That's my option. [SSO leader]

Some SSOs felt that HSOs were unprepared for the complexity of social services work. Some expressed concern that, in adopting projects such as AHC that employed a screen-and-refer approach, HSOs were not benefiting from SSOs' expertise working with individuals presenting with specific needs, as these quotes illustrate:

If the hospital is asking you about your housing and the hospital is not even setting you up with clothing to come home, what is the point? [SSO leader]

The population we are supporting are in very fragile and delicate positions. The patient may be a sex trafficking victim who has a "friend" who is simply there to watch and make sure they're not going to talk. The patient may have somebody who is an abusive partner, and even if the doctor asked the abuser to step out the room, the patient is terrified and not going to disclose it. If something were to be said in front of the abuser, there's a safety issue. So us not being part of the [referral] process can be harmful and unsafe. [HSOs] have good intentions but may not have been informed about a best practice way to do it. [SSO leader]

It's not enough to just put a roof over someone's head. It's huge to take someone from living outside to saying, "here's the keys, let's move you in." But the first

time I moved someone in and he showed up with a black plastic bag of his life's possessions, I was like, "oh, this isn't everything." It's great, but it's just a piece of the puzzle. [SSO leader]

Perceptions of Organizational Change. While duplication of programs and gaps in services were frequent points of frustration described by HSO and SSO leaders, there was also a sense that some organizations were resistant to change in pursuit of a more comprehensive and streamlined system. Interviews revealed some trepidation about multi-sector collaborations and the relinquishing of control it may require, as these quotes illustrate:

A lot of times entities create duplicate and duplicating services, staff and programs internally [instead of collaborating] in order to be able to control the data or the outcomes. [SSO leader]

There are parties that don't want to let go because anytime you partner, there's a degree of letting go of something in order to gain something. If one is used to operating in a certain way, opening the door to do it differently can sometimes be not attractive or fearful. [SSO leader].

Fear of change through partnerships manifested in concerns about mission alignment and the tension between adding new activities versus modifying existing ones when integrating new practices. HSO leaders described efforts to address SDoH as new work that would create additional burdens, but that was ultimately important to their population health promotion goals. Some described that it would be easier to adopt new workflows for organizations that had begun transitioning to value-based payments, or who were already strongly oriented toward mission-driven work. There was a desire for new work to be integrated within existing practices rather than requiring new staff or infrastructure. HSO leaders described a sense that many health service providers were not

ready for the kind of professional change that would be required to implement projects such as AHC and expressed concern that change could exacerbate existing power struggles in their organizations between physical health providers and professionals from other disciplines. Despite these concerns, HSO leaders largely described change as necessary, positive and worth the effort, as these quotes illustrate:

I think clients are better off. It adds more work for us, but at the same time we're providing more services and at least giving people information on resources that they might not get otherwise. [HSO leader]

This is a long time coming. The Oregon market is pretty ripe for more programs like AHC focusing on community-based and holistic care. Not having appropriate transportation, having food insecurity, constantly living in crisis mode, that is all going to drive costs and outcomes for healthcare. [HSO leader]

Generally speaking, SSO leaders did not express concerns about the operational burden of entering into partnerships with HSOs. Instead, SSO leaders were more likely to reflect on whether a potential partnership supported the work they were already trying to do or clients they were trying to serve, and how similar the potential partner organization was in size, scope or purpose to one's own organization, as these participants stated:

[The health system] is so broad and we're really focused on one specific group. It would be hard to narrow down, "why would we have this partnership?" It would be easier with folks that were doing similar things or working with similar people as us. It would be easier if missions and visions and client populations were closer aligned. [SSO leader]

We, like every other organization, are susceptible to being pulled out of our general structure by people who have money and say, "I'll give you money if you do this". And we're like, "oh, okay, we'll do that." And so when you say "adopt shared strategies," I always wonder, whose strategies are we adopting? [SSO leader]

There was a sense that SSO leaders perceived their perspective could be lost in these partnerships, and that in agreeing to partner with HSOs it was important not to lose their identity or “voice.” Some SSO leaders expressed mistrust at the motives of their potential HSO partners, worrying that interest in collaborating was driven by profit rather than mission objectives, as these quotes illustrate:

[The HSOs] want to make sure that working with people in poverty doesn’t offend anyone, that we only work with those that look worthy. So, it’s really good if I can show you pictures of children, and maybe I’ll show you an intact family, but I really don’t want to show you anything controversial or that makes you think we’re unsuccessful. [SSO leader]

With the kind of issues that people are facing, grassroots organizing is really at the heart of the solution, because nobody else is going to speak up for these folks. Everybody else is speaking up for their own political and financial interests -- even the health care folks. [SSO leader]

In summary, there were similarities in how HSO and SSO leaders described increasing awareness of the complexity of social problems and trends that were driving the need for multi-sector partnership, as well as a similar sense of being “siloeed” from one another and desiring to elevate the visibility of their organizations and priorities through collaborations with other organizations and service providers. Differences were apparent across sectors in whether leaders perceived the value of screening and referral networks to be generating data on unmet needs and identifying service gaps, or meeting client needs and reducing redundancy in services. While HSO leaders generally viewed multi-sector collaborations (and the organizational changes they required) as beneficial to their goals, SSO leaders expressed more reservation and skepticism about whether multi-sector projects supported their efforts. As is described further below, both groups

perceived power dynamics and power differences as risks that they considered within collaborative opportunities.

Task Structure

The Appropriateness Framework suggests that the “task structure” of collaboration is another dimension of decision making within collective action dilemmas (Weber, Kopelman and Messick, 2004). The task structure includes technical considerations such as a person’s perceived options, incentives and costs, regulations and rules to be followed, and sources of uncertainty, as well as social considerations including power dynamics, and norms or rules of behavior within a community. As with themes related to identity and perception, there were both similarities and differences in themes related to the task structure of collaborations among HSO and SSO leaders.

Both HSO and SSO leaders considered the technical or operational costs and benefits of multi-sector collaborations, which manifested through concerns about staff morale and retention, compliance, and financial sustainability.

Staff Morale and Workload. Among HSO leaders, staff turnover was a key consideration, and new work that seemed likely to irritate or frustrate staff was perceived as especially risky if it heightened concerns that employees would leave the organization. This was weighed against the potential for enhanced staff satisfaction and more rewarding relationships with clients, as these quotes demonstrate:

Our home visiting nurses are using [the AHC screener] a lot and it generates really good conversations with their clients. They like it. [HSO leader]

If it got to the point where it was a real burden, we would certainly think twice and say, "this is just proving to be too much and we're going to bow out." [HSO leader]

There are so many competing priorities that it can be really difficult to keep employees motivated and engaged when you're continually asking for one more thing, one more thing. [HSO leader]

In addition to considering staff satisfaction, HSO leaders considered the cost of staff training that was necessary when taking on a new activity, and whether the training or the new activities would pull staff away from existing revenue-generating work. This was perceived as both an initial cost and potentially an ongoing cost if an organization would need to train new employees any time turnover occurred. For example:

Among the people who do [the AHC screeners] who have the most patient face-to-face time, there's a lot of turnover. That makes it difficult because you get people trained, but then half of them are gone within a year's time. You have to constantly relearn the workflows. Even though we know it's important, there's only so much time that people have to do their jobs. [HSO leader]

While SSO leaders also worried about the impact of collaborations on staff satisfaction, they were less likely to express their concerns in terms of their own employee retention or turnover. More often, they worried that they would invest time in building relationships with HSOs only to have these efforts negated when the HSO's employee left their job and the SSO had to begin again with a new person, as this participant described:

The economy is good, so hopefully everybody stays in place for a while, but that's always the issue. You form partnerships and get connected and then people turn over, move on, retire, and you have to go back through the relationship rebuilding phase again. [SSO leader]

SSO leaders also frequently worried that new activities that were not financially sustainable could put them in the position of having to lay off their own staff in the future, rather than worrying about staff leaving voluntarily.

Compliance and Data Management. Compliance issues related to data management were considerations for both HSO and SSO leaders in collaborations, as well as the potential burden of new data collection and reporting. HSO leaders worried about compliance with rules for handling protected health information (Health Insurance Portability and Accountability Act, 1996) and governing the protection of health information related to substance use disorders (42 C.F.R. §2, 2017). While SSO leaders also worried about the handling and sharing of sensitive client information, they often perceived that they operated under more strict regulatory or ethical standards than their health service partners, such as attorney-client privilege or domestic violence advocate privilege, that prevented them from sharing information with health service partners for closed loop referrals even when they understood the value of information exchange. Both SSO and HSO leaders perceived particular risks in sharing data about immigrants and refugees. This was directly related to the perception that the current political climate was hostile to immigrants and could expose individuals to unwanted attention from government entities if their information was collected as part of a screening initiative such as AHC.

HSO leaders worried about investing time in screening projects such as AHC and then not generating adequate data on population needs to make the effort worthwhile. These concerns were weighed against the potential benefits of generating new data about unmet needs within the community, and being able to use data to more effectively allocate resources, as these quotes illustrate:

We were making sure that we had all of our ducks in the row as we were signing on to the Alternative Payment and Care Model program. One of the quadrants was

population management. So, how do you do that well and make sure that you're creating right-sized and right-fit programs to get to that population management? One way that a lot of other clinics were focusing on that work was through the AHC program. [HSO leader]

Our biggest concern is getting enough screenings completed that our data is meaningful to us. Because we are limited in staff who are available to do the screens, we know we're not going to have as much data as we wanted. That's what I worry about. [HSO leader]

We have a high needs population. Now we actually have data to say," in three weeks we had 260 patients come up positive on social determinants." That is the kind of data we just were not engaged in before. [HSO leader]

Similar to HSO leaders, SSO leaders also worried about the burden of monitoring and reporting duties on staff, particularly when collaborations with other organizations may require adding tracking systems or new reporting requirements. HSO monitoring and reporting systems for multi-sector partnerships were sometimes perceived as duplicative or competing with SSOs' own monitoring and reporting efforts, as this participant described:

We have a data system that we're trying to put in all our sites. My sites are resistant and I'm having challenges because they're already inundated by other folks also trying to track their same clients. It's duplication. [The HSOs] can see the same records, and that is great, but clients have to answer the same questions twice. [SSO leader]

The risk of duplicative screening or data collection was weighed by SSO leaders against the possibility of being able to better quantify the impact of their work on other organizations, which could potentially support fundraising efforts. For example:

We began [screening] because we thought if we had data and if this population is sharing what they do not have access to, it helps us with grant writing. Like, "we have screened this many people, and this is the response we've gotten." That could help potentially with grant funding for transportation or having funds available for

folks when their utilities are about to be shut off or finding a way to deliver food. So, for our purposes it's been very much grant writing, if you've got the numbers to justify to other community partners. [SSO leader]

It's a conversation we sometimes have about how much money we save the hospital by meeting with folks, helping them set up their appointments with their primary care provider and reminding them to attend that appointment. [SSO leader]

Financial Sustainability. Both HSO and SSO leaders considered whether new costs were offset by new revenue opportunities and, if so, how sustainable these new funding sources would be. Taking on new costs related to a collaboration, such as new staff positions or expanded infrastructure, was considered much less risky if new revenue sources were likely to be sustained over time rather than time limited. These SSO participants stated:

It's easier for agencies to get involved and invest a lot of time in hiring people, training, building out workspaces, and buying the computers, if we know that the contract and employees are going to be long-term and it's not an unknown from year to year whether the funding will continue. [SSO leader]

Money is part of it too, because [multi-sector collaborations] is a way that we can make money. When we're contracted with those [HSO] agencies and we're able to give them that information, the fee for service type of income helps with our sustainability. [SSO leader]

HSO and SSO leaders both considered whether a new collaboration opportunity would be consistent with their existing funders' expectations or priorities, particularly with Coordinated Care Organizations. If it conflicted with funder priorities, this was typically considered a reason to forego a collaboration opportunity. These participants stated:

With HRSA as one of our main stakeholders because of funding, we really have to make sure that all those pieces are hitting HRSA's requirements. [HSO leader]

You always want to have the blessing of the payer. So, if we're able to fulfill a strategic priority for them and for ourselves, you always look for that overlap.
[SSO leader]

Everyone's in their own little zone and our funders are in their own zone, so you have to play their game on some level. To then apply a new set of rules that a collaboration comes up with, and then also meet your funders' needs, you are inherently squeezed and stretched and maybe out of compliance somewhere.
[SSO leader]

In summary, HSO leaders weighed the technical risks of collaboration with particular attention to staff morale and the risk of employee turnover, while SSO leaders more often considered the risks of not being able to financially sustain staff positions. Within screening projects such as AHC, HSO leaders considered the risks of not generating sufficient screening data to make efforts worthwhile, while SSO leaders worried about the creation of redundant screening initiatives or infrastructure. Leaders in both fields considered whether new funding sources tied to collaboration were likely to be sustained over time, and how well new collaboration opportunities appeared to align with their existing funders' priorities.

In addition to technical considerations, both HSO and SSO leaders described social considerations in deciding whether they should pursue a collaborative opportunity, including whether a collaboration opportunity would enhance or undermine the organization's social standing in the community. Specifically, they considered whether or not there was a competitive dynamic with others in their region when entering into new partnerships, what mechanisms existed for holding others accountable, what power dynamics existed among the organizations involved, and how a partnership might affect the organization's reputation.

Competition and Credit. Among HSO leaders, competition with other HSOs was more likely to be accepted as an unavoidable aspect of one's work. This manifested as competition for workforce, market share, or clients. HSO leaders perceived that it was easier to take risks through multi-sector collaborations with SSOs when working in a less financially competitive market, as there was more flexibility for innovation and trying new approaches when one was not worried about losing clients to a competitor. These HSO leaders noted that competitive dynamics and concerns among HSOs tended to exist at executive levels even when there was a desire among front line staff to collaborate, as these quotes illustrate:

We get along with staff at the local hospital really well because we deliver babies there all the time, and our doctors go over there on a regular basis. On a staff-to-staff, staff-to-provider level, it's really strong, but you get into the upper echelons of leadership at these organizations and there's a lot of arrogance. There's a 'me first' mentality. It puts a small group like ours in a very defensive position. The desire to work with them is pretty low. [HSO leader]

Among the people on the ground doing the work, the collaboration is much more impactful than the competition. Competition happens at contracting levels and higher levels, but when it's about, 'how do we serve our community?' we have worked closely with [competitor]. But there can be a rub there. Sometimes people are really excited to come together. Sometimes they're not. So, that's something that every organization has to navigate. [HSO leader]

SSO leaders also considered competition with other SSOs for partnership opportunities, but more often described taking steps to actively avoid it in actuality or appearance. They were more likely than HSO leaders to describe considering whether another SSO in the community was already doing similar work, and to worry about the perception of stepping on toes or competing with other SSOs for funding, as these participants stated:

We do a community scan and look at who else is doing that type of work and whether we are stepping on anybody's toes, because you don't want to start a program that's identical if it's already going on and could be strengthened in a different way. [SSO leader]

[We ask] whether we are going to find value in pulling together a new partnership or revisiting an issue with those that we've already established partnerships with. [SSO leader]

We try to be cognizant of our skills and the most useful place for us to be spending our time and be aware that other people have other skills, that they're much better at their jobs than I am. We do have an attitude that is very "I'm a lawyer. I'm not a social worker. I'm not a teacher. I'm not a nurse." and try to be aware of that. [SSO leader]

It was rare that HSO leaders described being directly in competition with SSOs, although they did describe competition with other HSOs. SSO leaders described competition with HSOs for workforce such as community health workers or licensed clinical social workers. Since these staff positions were increasingly employed by both HSOs and SSOs, some felt they were in competition for these workers or risked losing existing employees if they collaborated too closely with other organizations, as these quotes illustrate:

[Large HSOs] create a whole infrastructure of employees and pay them a certain amount of money, which is way more than what [small organizations] can pay. So now we're in competition for employees and we can't compete. [HSO leader]

There can be a danger of staff affiliating with the [host organization] and even becoming their employees. It's hard to manage. It's even harder when people are fully integrated in someone else's building and their culture. [SSO leader]

SSO leaders also perceived competition with HSOs in claiming credit for jointly produced outcomes. Some SSOs reported past instances where they felt HSOs had taken credit for population health outcomes that were the result of SSO efforts in the

community. This issue of claiming credit was perceived by some participants as a risk if they bore costs in a collaboration but then did not receive attribution for the results. These participants stated:

That's what I have trouble with is they come in, good things are happening already, and then they turn around and take credit. [SSO leader]

I don't want us to be left holding the ball if something goes wrong. I have to know that [our partners] are always going to support us and what we need. [SSO leader]

The health care institutions, instead of trying to become everything to everyone, if they were more focused on what their specialty was and brought in the expertise that is already existing in the community, then that's where accountability comes in. Otherwise you're wasting resources on both sides. [SSO leader]

Accountability. Within HSOs, the concept of accountability for performance was accepted as an inherent aspect of one's work, including the importance of having well-articulated reporting structures, transparent measures of performance, and documented workflows. One of the perceived values of projects such as AHC was that it would hold HSOs accountable for addressing social determinants of health in a consistent way and ensuring that efforts to collaborate with other organizations were consistently documented for external stakeholders. This concept of accountability also included holding HSO providers and staff accountable for having difficult conversations, acknowledging trauma in their work, and paying attention to health equity in their outcomes. These participants stated:

AHC has really sparked conversation between providers, like, 'no, this is our job.' Some providers are more progressive in that sense. So it's been really healthy, but it's also helped us to do some trauma informed trainings, bringing our behavioral health provider more frequently into conversations with patients, which is great. [HSO leader]

It holds accountability for doing the work. So then you create really structured workflows and processes for it that are also documented, right? There's some accountability to document the work that you're going to do and saying who's going to hold what? [HSO leader]

I think making it as clear up front, "here are the things that you will be required to do. Here are the checks." ... If there was a scaled plan of the milestones for when you need to have what completed by, I think would be helpful. [HSO leader]

Within SSOs, the concept of accountability was viewed with some skepticism, and some perceived that the term accountability was used euphemistically to mean SSOs becoming accountable to HSOs in exchange for money, rather than both sectors moving toward mutual accountability to each other and the communities they served. A strong theme emerged among SSO interviews that SSO leaders felt at a disadvantage in holding their HSO partners accountable within collaborations, often due to perceived differences in size, budget, or influence, as these participants' quotes illustrate:

Accountability is really interesting, because accountability is the one thing health care holds everybody else to but is really not willing to give up. [SSO leader]

[Holding an HSO partner accountable] would be impossible. Their decision makers are too far removed from the ground level. So, it's even more than not knowing the language each other is speaking. They just have no idea. They wouldn't even care. [SSO leader]

It would be much harder for us to go to [health system] and say, "you said this was your part, this is our part. We have done our part and you haven't done your part." I think it could be much more easily dismissed as "well, you guys are small. We're big. We have other things [that] are our top priorities." It would be much easier [with organizations we have relationships with]. They are our community partners, but they're also our friends. We see each other at networking events, and we discuss clients and we go to lunch. It would be easier to have those conversations when you have that relationship behind it. With those bigger systems, it's really hard to narrow down that relationship piece, especially if you have it with just one person and that one person is part of this giant system. If

something goes wrong, it's almost like it's just that person as opposed to the system behind them. [SSO leader]

Power Dynamics. When asked what it meant to hold power in a partnership, both HSO and SSO leaders described examples including 1) being a large organization or having access to a large population of people using services; 2) holding financial resources or decision making over the allocation of resources; or 3) having the ability to legitimize or de-legitimize a collaborative effort in the community by either endorsing or withholding one's support. Organizations holding power were identified by both groups as large health systems and health service organizations, CCOs and health councils, physicians and executive level staff within organizations. Some HSO leaders additionally identified convening organizations such as ORPRN as holding power to influence collaborations, directly or indirectly, while SSO leaders additionally described large nonprofits, public agencies and philanthropic foundations holding power in collaborations, as these quotes illustrate:

[Foundation] recently created a whole new collaborative and said, "actually it's happening over here." They were kind of ill-informed and didn't have a lot of the data, and then all the people who had been at this other group went to that group and were like, "Whoa, what's happening here?" So, things like that happen, or you think you've brought everyone to the table and then people say, "I felt so excluded and now I'm going to create my own thing because it was such an exclusive process." So not to be negative, but it just takes constant maintenance. [SSO leader]

Conversely, when asked what it meant to lack power or agency in a partnership, participants described struggling to be included in community conversations, not being invited to participate, or not having capacity to participate even if invited. Perceiving a need to "chase funding" and not being able to say no to a funder's request, as well as

needing to refer away clients when one cannot meet their needs, were also described as ways that organizations lacked power in collaborations. Participants described small nonprofits and small independent clinical practices as lacking power in collaborations, along with social service providers, mental health and/or peer support agencies, as well as individual employees at large health service organizations who were forced to make referrals rather than directly meeting individuals' needs. One participant described the power dynamic that existed with the CCO in the region as follows:

[CCO] are the ones that have the power and the money. I don't think that people agree with them necessarily or like working for them, but it's a huge power difference. To get money and work within the system, you have to do that. ... So we end up changing our focus to be what they think is most important. [HSO leader]

Certain groups were identified as neither holding nor lacking power, but as being absent from community collaborations altogether. These groups tended to vary between HSO and SSO leaders. HSO leaders identified county mental health and other elected officials as missing, as well as representatives of other regional SDoH initiatives who could share their perspectives and lessons learned. SSO leaders were more likely to describe communities of color, justice system representatives, business and civic leaders, and other social service agencies as missing from community collaborations. Both HSO and SSO leaders identified elected officials and local government as missing from community conversations about SDoH partnerships, as this participant described:

I think some of our business leaders, some of our civic leaders, could be more involved. Even elected officials being really connected to the work. I see a ton of work that city councils are doing around homelessness, for instance, that seems to be happening outside of any knowledge of the mental health or social determinant

service providers. Those decisions are happening in weird siloes and the right hand is not talking to the left. [SSO leader]

Reputation. Finally, both HSO and SSO leaders gave strong consideration to how a potential partnership could impact the organization's credibility or reputation in the community. For HSOs, this manifested as the ability to fulfill one's obligations and meet performance targets. In the context of the AHC project, this specifically manifested as concern about not being able to meet the targets or goals for the number of individuals to be screened; this concern was prevalent among interviewees even though these targets were understood to be goals rather than requirements. One participant stated:

When we agreed to participate in [the AHC] program, we were given a certain number of screenings that we were expected to do. We wanted to be able to deliver on what we had tentatively agreed to do, even though it's all pretty fluid. [HSO leader]

SSO leaders also strongly considered the potential effect of partnerships on their organizations' reputation, though this was often considered through the lens of how credible or powerful a potential partner was perceived to be, and how becoming affiliated with that partner could enhance or undermine one's own legitimacy. Some also perceived that entering into a partnership with an HSO had the potential to bring legitimacy or validation to one's mission or service delivery model, and that partnerships could be beneficial if they validated one's efforts. One participant stated:

It just improves our clout. It's great for me to have them at the table with me, a little nonprofit director, with her staff of three people, sitting down at the table with [health system]. That's fantastic for us. [SSO leader]

Conversely, some SSOs perceived that regional health collaborations such as community health improvement plans were a threat when these processes resulted in the

community adopting shared goals that did not include one's mission, service area or priority population, as this could marginalize one's work or make it harder to get attention focused on one's priorities. For example:

We sometimes do feel like we're not spoken for. We're told "you need to collaborate with somebody who's doing children and families," or "you need to write collaborative grants on that." Okay. But there's still this huge portion of our population... Boomers are turning 55 at a crazy rate today. Right? There is this older adult population that funders are forgetting about, and that's a challenge.
[SSO leader]

In summary, HSO and SSO leaders weighed the social aspects of collaborations differently, including competition, power dynamics, and accountability within a potential partnership as well as the potential effect on the organization's reputation. HSO leaders' perspectives revealed that while they rarely perceived competition with SSOs, they understood competition with other HSOs to be an unavoidable aspect of one's work and one that made collaboration more difficult. Competition was often managed by HSOs through performance management efforts that could position the HSO as more effective or capable than its competitors. In contrast, SSO leaders described competition (with SSOs and HSOs) as something to be actively avoided, and often expressed frustration at perceptions of HSOs claiming credit or resources for joint efforts.

Both HSO and SSO leaders perceived power dynamics within collaborations that favored larger organizations (particularly hospitals, large health systems and CCOs) and physical health care providers. Control over community meetings and planning processes was identified as a key setting where these dynamics occurred. While HSO leaders spoke of contracts and performance measures as a way to hold one another accountable in collaborations, SSO leaders expressed skepticism that they could successfully leverage

these tools to prevent HSOs from exploiting them within partnerships. Despite the risk of losing credit for one's work, SSO leaders perceived collaboration as sometimes being worth the risk if a partnership with an HSO could enhance the SSO's credibility.

Summary of Sector Variation

The similarities and differences in themes related to identity, perception and task structure that emerged between health and social service sectors, which were described in this and previous sections, are summarized in Table 4.2. In brief, comparison of themes related to HSO and SSO identity revealed that HSO leaders more often framed their motives in the context of system-wide transformation and prioritized the prevention of burnout (in themselves and their staff), while SSO leaders' motives related to sustaining their efforts and ensuring that their priority issues and populations were spoken for.

HSO leaders perceived value in projects such as AHC for identifying gaps in services in the community but weighed the risks that these efforts may not generate enough data to be worth new burdens on staff or risks to an HSO's reputation for high performance. In contrast, SSO leaders perceived a risk of redundancy in community screening and data collection efforts and weighed this risk against the potential for new or more sustainable funding or enhanced organizational legitimacy. Variation in these themes was further explored across the four AHC regions, and observed similarities and differences are further described in the following section.

Table 4.2: Key Themes by Sector

Constructs [and Domains]	Themes from Health Service Leaders	Themes from Social Service Leaders
Personal Motives [Identity]	Service, fairness, dignity, efficiency, work/life balance	Service, fairness, dignity, efficiency, “saying yes”
Organizational Motives [Identity]	Transform systems through population health management; build on efforts to address SdoH	Serve priority populations; help individuals navigate systems; ensure SSO perspective is reflected in HSO efforts
Stakeholders and Responsibilities [Identity]	Improve health status of clients; protect staff morale and retention; align services with community priorities and deliver on commitments	Provide options to clients; protect staff job security and minimize layoffs; align services with mission and values; ensure groups are represented in community conversations
Problems [Perception of the Situation]	Social changes drive increased needs; Sectors operate in siloes leading to feeling invisible or misunderstood; current efforts suffer from inability to measure needs and gaps	Social changes drive increased needs; Sectors operate in siloes leading to feeling invisible or misunderstood; current efforts lead to churn, redundancy and duplication of services
Improvements [Perception of the Situation]	New activities should reduce reliance on fee-for-service reimbursements; integrate with existing services.	New activities should increase fee-for-service reimbursements; Partners should be similar in size or mission.
Technical Considerations [Task Structure]	Minimize staff turnover and time burden of training; maintain compliance with data privacy regulations; balance burdens of data collection with benefits for population health management; avoid conflict with funder priorities.	Minimize funding uncertainty and time burden of community meetings; maintain compliance with standards for client privilege; balance burdens of data collection with benefits for fundraising and advocacy; avoid conflict with funder priorities.
Social Considerations [Task Structure]	HSOs perceived little competition with SSOs, but competition with other HSOs is unavoidable; collaboration with SSOs is easier without HSO competitors Performance management is a tool for mutual accountability; reputation is enhanced by demonstrating the organization met its commitments	SSOs perceived competition existed with HSOs for workforce and claiming credit for joint outcomes; collaboration with HSOs can risk duplicating work of other SSOs, which should be avoided SSOs lack tools to hold HSOs accountable and risk adopting others’ goals for money; reputation is enhanced through HSOs’ legitimacy and resources

Variation Among Regions

The key themes described in the prior section reflect similarities and differences in identity, perception and task structure that emerged when participants were segmented by health or social service sectors. Variation in these themes across the four AHC regions is further explored in this section. To facilitate the comparison of regions, survey data are dis-aggregated and presented at the regional level to highlight similarities and differences in participants' organizational characteristics and collaborative activities across regions. This section also includes a description of findings from network mapping (described in Chapter Three) that was conducted during the coding stage in order to index and compare participants' references to community meetings, coalitions and groups where they were engaging in multi-sector efforts with other organizations in their regions. The four AHC regions were de-identified throughout this section to protect the confidentiality of participants and their organizations.

Identity

There were similarities and differences among regions in how participants described their backgrounds and the degree to which they described having strong ties to the region in which they worked. Differences were also noted across regions in how participants described their organizations, the other organizations serving the region, and the region's collective identity as collaborative or competitive.

Personal and Organizational Identities. The research participants from Region A included leaders from primary care (2), care coordination, housing, emergency food and behavioral health services. The organizations from Region A that completed a survey

(n=5 out of 6) were, on average, larger by budget size than the organizations in other AHC regions. Three of the five organizations had budgets of \$5 million per year or more, and all had budgets greater than \$1 million per year. With the exception of one locally based organization, all participant organizations in Region A were part of larger state, national or international organizations, providing services to the region but headquartered elsewhere. While HSO and SSO leaders from Region A described personal values related to service, collaboration and giving back to their communities, several also reported that because their organizations provided services across a number of geographically dispersed sites or unique programs, this could create challenges for trying to achieve support from internal stakeholders for local collaborative efforts. For example:

We have a lot of sites, and one might think that there are some basic procedures and protocols that are followed universally at all the clinics, but that's just not true. Each clinic has its own culture, its own manager, and so it's almost like starting a new project at each clinic. That part of it can be quite challenging.
[HSO leader, Region A]

The research participants from Region B included a primary care wellness center, a Coordinated Care Organization (CCO), an Area Agency on Aging (AAA), a nonprofit domestic violence and sexual assault support agency, a Community Action Agency, and a volunteer-run transportation assistance program. The organizations from Region B that completed a survey (n=6 out of 6) were also larger by mean budget size than the organizational average for this study; half of the organizations had annual budgets of \$5 million per year or more, and five of six had annual budgets greater than \$1 million per year. In contrast to Region A, Region B organizations were headquartered in Region B

and their services were primarily provided within the region. Most Region B participants were from the region originally and expressed strong ties to the region. For example:

I have lived most of about 40 years in [Region B]. [SSO leader, Region B]

I am born and raised, third generation [Region B]. [HCO leader, Region B]

The participants from Region C included leaders from a public health department, a housing authority, a nonprofit focused on immigrant and refugee aid, an oral health organization and a regional food bank. The organizations from Region C that completed a survey (n=5 out of 5) were, on average, the smallest of the organizations in this study; two reported budgets of less than \$1 million per year, and four had budgets of \$5 million per year or less, while one was a subsidiary of a large parent organization with a national service delivery network. While participants in Region C had similar lengths of service with their organizations to participants in other AHC regions, none were originally from the Region C area and all had relocated there for work purposes or worked remotely from other areas. As in Region A, Region C's participants described that it was common for organizations in the area to be headquartered elsewhere:

This is a small community. There are not very many organizations, and a lot of places that serve this area don't have offices in this area. They're often out of those conversations. I think that's somewhat common in rural areas. Certainly, our office serves a large area, and we're not there on a daily basis to be involved in those conversations. It matters who's physically there in the room. [SSO leader, Region C]

We have a statewide hub and spoke model where we have a lot of different satellite offices, so the communication pathways can make things difficult. There are competing priorities from different levels [of the organization]. [HSO leader in Region C who worked remotely from another area]

The participants from Region D included leaders from a public health department, a community action agency, a primary care clinic, a housing case management organization and an Area Agency on Aging. The organizations from Region D that completed a survey (n= 5 out of 6) ranged in budget size; two had operating budgets between \$1 and 5 million per year, one was larger (greater than \$5 million per year) and one was smaller (less than \$1 million per year), making them collectively smaller on average than the study population as a whole. Region D's participants were a mix of individuals who were originally from the area and others who had relocated there, but in the latter case, had resided in the area for many years and described strong ties to the region. All Region D organizations were headquartered in the area and several described being located in close proximity to one another. For example:

We happen to be catty-corner, literally across the street from [other organization] and on their route. [HSO leader, Region D]

The [SSO] is part time and they actually sit in one of our buildings just across the street, kitty corner. We also have the agency that does [SSO service] that sits in our building, and we have the [other SSO service] here also. [HSO leader, Region D]

Regional Identity. Region A participants rarely describe their region as a community, instead discussing their internal organizational cultures or professional networks they identified with that were not geographically bound. Compared with other AHC regions, there was little discussion of Region A as a place where collaborations occurred, and Region A leaders often described frustration at the lack of local leadership to drive collaborations, as these quotes illustrate:

Somebody needs to take their hat off and say, "I have the powers to pull all these people together into a room and figure it out." ... I think that's what's wrong in the

big picture. I don't think we're trying to change the whole system. I wish there were people that had more power that were trying to do that. [HSO leader, Region A]

What ends up happening is people are very protective of their systems and not wanting to disrupt the system to have less duplication of work. [HSO leader, Region A]

In contrast to Region A, participants in Region B frequently described collaborations and partnerships as part of the identity of the region, as illustrated by these quotes:

The nature of our community here is we have really open and willing individuals wanting to engage. [SSO leader, Region B]

My perspective is that this county is actually pretty ahead of the curve. [SSO leader, Region B]

In addition, leaders from Region B described being locally oriented in their decision making and not looking outside of the community for leadership on collaborative efforts, as these quotes illustrate:

Her initial reaction when she learned about [the AHC project] was that it wouldn't serve us well to be collecting data for CMS. She didn't see how it would have any particular impact on the work that we do locally. [HSO leader, Region B]

An agency in [other urban county] would not be doing this same thing that we would be doing in [our] counties. The needs are different. [SSO leader, Region B]

Region C viewed their community as a place that struggled to collaborate, which participants often attributed to conflicting internal priorities given that organizations often reported to leaders outside the community; this was coupled with a sense of resignation among some participants. For example:

Everybody else is speaking up for their political interests and their financial interests. Even the health care folks. [SSO leader, Region C]

It's difficult when you have people from upper management making these decisions but not necessarily being the boots on the ground. [HCO leader, Region C]

Everybody has their own agenda and their own time frames and their own parameters, and organizations aren't funded the same. They're not managed the same. Their goals aren't necessarily the same. So sometimes it can be hard to pull all of that together. I think everyone's overarching goal is to serve the client, and I think that with a lot of our partner organizations, we share our client base. So our ultimate goal is the same, to meet their needs, but we're all coming at it from different directions. [HCO leader, Region C]

I think change just takes a long time. I think that systems just kind of get set in their ways in how they do things. [SSO leader, Region C]

Region D participants described their region as mostly collaborative and working together under local leadership. While participants did express some frustration about working with specific organizational partners, the region as a whole was described positively as having success developing shared goals and working together, as these quotes demonstrate:

I don't find collaboration hard. One of the things we focus on here is really our regional health improvement plan. So, people have shared goals around things. We also have the [other local council]. [HCO leader, Region D]

We were fortunate in that we've been doing a lot of work here with our other partners. We weren't as siloed and I think that made [AHC] easier to some degree. [HCO leader, Region D]

In summary, Regions A and C were represented in this research by participants who described weak ties to the community; many had relocated to the area for work in the recent past and their organizations were often headquartered outside the area. Region A and C participants described their regions as struggling to collaborate across sectors to address SDoH, which many attributed to organizations having conflicting priorities, or

leaders who were not based in the area and did not prioritize local concerns. Regions B and D were represented in this research by participants who described relatively stronger ties to their local communities. Organizations in Regions B and D were mostly headquartered within and focused on serving those regions. Participants described Regions B and D as relatively collaborative in nature, and tended to look to the local community for leadership on multi-sector collaborations to address SDoH.

These participant descriptions of their regions were compared with survey data collected for this research. Participants were asked in surveys to identify which types of health and social services, if any, their organizations provided in collaboration with others. Survey responses were dis-aggregated by region and revealed differences across the four AHC regions in the average number of service collaborations that participants reported. These differences were small, but generally validated participants' descriptions of their regional collaborative activity (though these results are not representative of other organizations in the regions). Region B and D participants generally described their regions as collaborative, and the Region D participants who completed a survey (n=4 out of 5) reported an average of 10.75 services currently provided through collaborations (the highest among the four regions). Region B participants completing a survey (n=6 out of 6) reported the second highest levels of service collaborations among the regions (9.33). The participants completing surveys in Regions A (n=5 out of 6) and C (n= 5 out of 5) described struggling to collaborate, and survey responses also revealed slightly lower average numbers of service collaborations in Region A (9.20), and Region C (8.80) (Figure 4.7).

Figure 4.7: Average Number of Services Currently Provided via Collaborations

Perception of the Situation

As previously described, the Appropriateness Framework (Weber, Kopelman and Messick, 2004) depicts an individual's perception of the situation as an important element of decision making in collective action dilemmas. There were differences among regions in how participants described the problems they were trying to overcome through multi-sector collaborations -- either as challenges primarily relating to people and relationships, or to capacity and resource shortfalls. Differences were also noted across regions in how participants described the way that multi-sector collaborations did or did not provide value for their organization, and the degree to which participants described a specific purpose for the region's collaborative efforts. These differences are described below.

Problematic People versus Problematic Systems. When asked about the kinds of problems multi-sector collaborations could address, participants in Region A tended to describe problems in terms of people and the organizations with which they worked. For example, these Region A participants described people within organizations who did not see the bigger picture or did not strive to work together as the problem:

[Health and social service organizations] are really just focused on what's being presented them to them at the moment rather than trying to take a holistic look at the person. Different nonprofit agencies and health care agencies just don't talk to each other. [HCO leader, Region A]

These problems have not just been occurring recently. These are problems that have occurred for many, many years. A lot of the organizations here, the community organizations, always network, but sometimes they don't really communicate. [SSO leader, Region A]

In some cases, Region A participants described lack of buy-in from internal stakeholders or conflict within their own organizations as the problem to be overcome.

For example:

We need to tear down our systems. Yes, we have four different departments working on this, but no one actually working on it. From a conceptual place, absolutely, but not in the trenches. [HCO leader, Region A]

Creating a new set of goals that are above and beyond our own goals and actually might not complement them fully, that's a huge barrier. To even explain that to my staff... I'm part of a lot of those collective impact discussions. My staff spend 90% of their time meeting funder requirements and are indoctrinated in those. To ask them to respond to a new set of goals feels just arduous and unrealistic. [SSO leader, Region A]

In contrast to Region A participants' focus on the problem of people and organizations, the nature of the problem being solved through collaborations was described in Region B in more technical terms. Problems were considered in the context of larger social trends or changes. Region B participants suggested that the problems to be solved through collaborations related to lack of structured processes or technology to coordinate efforts or use resources more efficiently to meet growing needs or worsening social conditions, as these quotes illustrate:

In a small community like ours some of the challenges that are trying to be addressed [through collaboration] is the duplication of services or work ... We don't have the technologies that can best suit us. We as a community have not agreed on a software platform that allows us to communicate about what the patient is getting. [HSO leader, Region B]

The cost of care for individuals and the need is so out of whack. Social challenges are magnifying, because we have generations moving into elder years in such a large number. The cost around that, particularly in the hospitals, is so expensive. Not having adequate space for severely mentally challenged individuals to get the care they need. Oregon is facing enormous challenges in that arena. [SSO leader, Region B]

Participants in Region B also expressed frustration that local collaborative efforts moved more slowly than they would like, as these quotes illustrate:

We were waiting and waiting for a steering committee meeting because we thought that would be the opportunity to really share and say, "This isn't moving [fast enough] in our community. What are you doing in your community?" It took a long time. [HSO leader, Region B]

The one [CCO] work group that hasn't launched yet is the older adult work group. We would like to be one of the leaders to get that group together. That hasn't come off the ground yet either, but I think that'll be an important factor when that does launch. [SSO leader, Region B]

Similarly to Region A, Region C participants more often spoke of the problem to be solved by collaborations in terms of problems they perceived with other people or organizations, including organizations lacking the ability to meet needs internally, or clients that might not trust the organization enough to share sensitive information. Region C participants sometimes expressed cynicism that their partner organizations were motivated by financial interests or looking for shortcuts rather than meeting community needs, as these quotes illustrate:

Referral networks are being funded because people are looking for shortcuts.
[SSO leader, Region C]

The local CCO doesn't understand, because dollars are what matters to them. Just getting them to understand and take into account the social services side of it, that people will stop calling you back... That's just dealing with people. [SSO leader, Region C]

In contrast, Region D participants reported that lack of services in their community was the underlying problem to be solved through collaborations, rather than better relationships among people and organizations, or coordination of services, as these quotes demonstrate:

I think the bigger issue is whether the services are available. One of the challenges here - not everywhere, but in [this] county - is that access to care is still really hard for people. [HSO leader, Region D]

One of the big issues - especially in [town] - is transportation. The transportation system is based out of [nearby city] and they do come here, but it's not used very much because it's not convenient and people can't get to appointments on time. So, transportation is still a huge issue for us. [HSO leader, Region D]

Region D participants (like Region B) attributed the need for collaborations to worsening social conditions or government hostility toward people seeking services, including immigrants and refugees. For example:

I think that nationwide there's a bigger awareness of mental health issues. I think that communities are trying to [address] homelessness, so they're pulling together to try to solve a lot of these problems that are popping up. [SSO leader, Region D]

The government right now basically makes it sound like you're the worst person on the face of the earth if you're receiving services. It's a nightmare. It's a lot worse than it has been. [HSO leader, Region D]

You put someone like [the president] in office and then we're all scared about folks that are struggling the most. How much better do we have to get with the

resources we have so that we don't lose those people in four years' time? [SSO leader, Region D]

Similar to Region B, Region D participants also attributed the need for collaborations to demographic changes and an aging population in the region, as these quotes illustrate:

The influx of older adults here is surprising. They don't necessarily have spouses or children, so that natural support system that has historically been in place... it's not going to be that way. So how do we as a community come together and recognize that we're going to have all of these people who might not have access to the natural support that we once had? I really think that's a big concern for us. [SSO leader, Region D]

I think the [lack of] extended family is also problematic. A lot of people move here and they don't have extended family, and then find that it's hard to find a job or housing or anything. So that's a challenge for Oregon. [HSO leader, Region D]

Clarity of Purpose and Value of Multi-Sector Collaborations. Participants across regions expressed different reasons why multi-sector partnerships would be of value to their organizations. Region A's leaders exhibited less clarity about the purpose of collaborations than participants in other regions. Some struggled to articulate the value, and perceived existing collaborative efforts to be ineffective or of low value. For example:

I don't know that anybody can really say what value we're really anticipating getting back, or what the value is of collecting social determinants of health data. All I've heard is "for the wellness of our patients," but I don't know that there's any numbers. [HCO leader, Region A]

Region A leaders also strongly emphasized that new work needed to pay for itself and considered financial implications at the start of a potential partnership. Projects such as AHC were not necessarily seen as a financial risk, but new collaborative work, in

general, was described as a risk if it did not have sustainable revenue. As one participant stated:

[Collaboration] is just not realistic with the resources that we have. Then there's the administrative time it takes to develop those goals and maintain and align those. You're just driving your administrative overhead and meeting time through the roof. [SSO leader, Region A]

In contrast, some participants described Region B as a community that had already been working on SDoH initiatives prior to the launch of the AHC project, with AHC providing value through a more structured process. Obtaining data about local needs was frequently expressed by participants in Region B as a desirable outcome of multi-sector collaborations, whether it was data on individual needs collected through screenings, or data on the larger regional service delivery network, as these quotes illustrate:

My colleague was really excited about the potential that this project could have in terms of reaching people with screenings around social determinants of health. She felt the data that we would receive through this process would really help us to allocate our resources or identify gaps that could inform our plans going forward. [HSO leader, Region B]

There are other ways that this initiative could really benefit the community in a larger way, and that is to get the outcomes broadly shared around the region so it's not just to the clinical sites that have done the research, but allows those who are social service providers to expand their thinking on how to improve what they're doing to support those clients. [SSO leader, Region B]

We were already doing the work. We just didn't have a really structured process for how to do it, or support through technology, or thinking about how this could be incentivized to help it keep happening. [HSO leader, Region B]

In contrast, participants in Region C expressed doubts about the usefulness of screening and referral models as a tool for enhancing collaborations or meeting

community needs. Some region C participants were also part of another care coordination project similar to AHC that had launched previously. As these quotes illustrate, there were also mixed perceptions of the effectiveness of that effort, with some viewing it positively while others perceived that the project had surfaced tensions between health and social service partners prior to the launch of the AHC project:

I think [other care coordination program] is great. It's working really well. We've had many, many successes. [HSO leader, Region C]

The way [other care coordination program] is currently operating is based on how much time they put into the program, but [the HSOs] are wanting to move towards outcome based [payment] and there's a lot of pushback from the [SSOs] saying, "we could put four weeks of work into a person and then they can just disappear on you and never call you back, and then we don't get paid for the four weeks of work we did." So, there's that butting heads of the two worlds. [SSO leader, Region C]

I don't know that it's improving relationships or communications. It feels like it is still siloed in our clinics that are participating. They're just simply doing the screenings on the tablet and then, based on the responses, get the printout and they hand that to the member. I don't know that that's really helping to drive partnerships. [HSO leader, Region C]

When Region C leaders' descriptions of the purpose or value of projects such as AHC were positive, they often described raising awareness of their own programs and services. As these participants stated:

That's a great part about being involved in [screening and referral networks] is teaching other agencies about all of the work that we do as a public health agency. [HSO leader, Region C]

People have a vague understanding of what housing authorities do, but that often leads to a lot of misunderstanding and misinformation about our programs. The more that we can get out there and get the right information out, the better. [SSO leader, Region C]

In contrast, Region D's participants articulated a stronger value proposition for multi-sector collaborations in general, while perceptions of the value of screening and referral networks specifically were mixed. Several Region D participants describing referral networks as an important component of a holistic strategy, though insufficient to address all unmet needs:

For some, [screening and referral] works really well and for some it probably doesn't. We can hand out phone numbers and connect people as much as we want, but capacity and all these different factors can come into play. [SSO leader, Region D]

I think [screening and referral] is certainly a good approach. I think it shouldn't be the only approach. [SSO leader, Region D]

[Screening and referral] is the right approach, because unless you ask people, they're not going to just come up and say they have something going on. Some do - it depends on the setting - but I think it's the beginning of an approach to try to address [needs]. [HSO leader, Region D]

In summary, when considering the nature of the problem that multi-sector collaborations were intended to solve, the participants in Region A and C tended to describe problems in terms of people or organizations, including their beliefs, attitudes, or behaviors. It was not uncommon for participants in Region A and C to identify specific organizations or groups of people to whom they attributed problems, including occasionally individuals within their own organizations. Participants in Region A and C also struggled to articulate a value proposition for participating in multi-sector collaborations, tending to focus on costs and financial sustainability. Some worried that referral networks were a way for partner organizations to shift the burden of unmet needs to other organizations in the community. In contrast, participants in Regions B and D

articulated a stronger purpose for collaborations that was often directly related to rising social needs in their communities and eroding social and governmental support for specific vulnerable populations. Participants in Regions B and D focused on the value of multi-sector collaborations for strengthening relationships, collecting data for planning or enhancing program capacity.

Task Structure

There were differences among regions in how participants described the regional context (or “task structure”) in which they worked and how this shaped their perceptions of collaboration risk. Differences were apparent across regions when participants described how local organizations engaged with one another, including the relative visibility, clarity and perceived duplication of community meetings or groups, which organizations in the community functioned as conveners and the degree to which the convener role appeared to be contested among organizations. Differences were also apparent in the regional group dynamics and social structures described by participants in interviews, including the degree to which other organizations were described as collaborative or competitive, and whether participants described being in competition with one another for resources. These differences are further explored and compared below. In addition to comparison of themes from interview data, network mapping (i.e. a diagram depicting the interorganizational connections described by participants across all of a region’s interviews and surveys) was used to index and compare the collaborative activities that participants described, such as alliances that participants identified as being

members of, or community meetings that participants described attending or relying on to connect with other organizations in the community.

Variation in Regional Conveners and Meeting Structures. The participants in Region A described unclear or absent regional leadership for multi-sector collaborations. In contrast to other regions where the CCO was described as a lead convener for the community around efforts to address SDoH, the CCO in Region A was described as not being engaged in the community and as difficult to work with, as these quotes illustrate:

The CCO here in town... I know for a fact that they have a lot of funding. A lot of the CCOs have gotten a lot of funding to try to provide services to the community. I've been surprised that they haven't reached out to us to see what they can come and do at our sites. [SSO leader, Region A]

[The CCOs] are the ones that have the power and the money. I don't think that people agree with them necessarily or like working for them, but it's a huge power differential. So to get money and work within the system, you have to do that. [HSO leader, Region A]

Despite this weak role of the CCO, no other organization was identified by participants as a convener or leader of multi-sector collaborations in the region other than ORPRN, through their efforts to launch the AHC project in the community. Several participants referred to broader regional collaborations such as a coordinated regional response to opioid overdoses that were actually taking place in neighboring communities and were described by Region A leaders as models their organizations aspired to replicate, rather than work they participated in for Region A's benefit. Some Region A participants made reference to other collective impact efforts in the region in a disparaging way, as this quote illustrates:

Frankly, the organizations that are responsible for collective impact do a horrible job of making it easy for [others] to interface. They keep talking about it, but they don't make it easy. They don't do what it takes to help someone plug in. [SSO leader, Region A]

Region A participants described being disconnected from one another and not knowing how or where to engage with organizations from other sectors in their community. When community meetings were named, they were not consistently identified by more than one participant as venues for multi-sector relationship building. Network mapping of Region A confirmed that community meetings or alliances that were named as venues for multi-sector collaborations in participant interviews or surveys, including CCO meetings, were generally mentioned only by a single participant and not by other participants, in contrast with other regions where multiple research participants often described participating in the same collaborative meetings. Some Region A participants expressed frustration that existing regional collaborative meetings were constantly being renegotiated, as this quote illustrates:

It's always that [others] want to be at the table, but they don't show up to the meetings, or they think the table should look different. Maybe they're right. I'm not judging that. But what is "the table"? We recently had an experience where a local foundation leader created a whole new table and said, "actually it's happening over here." Then all the people who had been at this other table went to that table and were like, "Whoa, what's happening here?" So things like that happen where you think you've brought everyone to the table and then people are like, "I felt so excluded and so now I'm going to create my own thing because it was such an exclusive process." So it's a moving target, and not to be negative, but it just takes constant maintenance. [SSO leader, Region A]

In contrast to Region A, Region B participants described high levels of coordination and collaborative planning through community meetings, as well as direct inter-organizational partnerships to coordinate or co-locate services. CCOs serving

Region B were described positively as playing a strong role in leading regional efforts to address SDoH, and participants in Region B did not describe other organizations vying for leadership or control of meetings, as these quotes illustrate:

[Group] is probably one of the biggest influencers. There's just a really dynamic interplay of information and sharing. The CCOs are represented on that group too. So if I had to define the strongest influencers, I would say [that group] are, because they represent so much of what our region does. [SSO leader, Region B]

For the most part in our community, certainly since the inception of the CCOs, there has been a lot of success around shared goals. [HSO leader, Region B]

We have a very collaborative process around our community health assessment and community health improvement plan. [HSO leader, Region B]

Region B participants identified specific community meetings as hubs where multi-sector coordination was occurring, and network mapping confirmed that the same regional alliance and CCO meetings were identified consistently by multiple interviewees. However, despite broad recognition of the importance of these groups in convening local partners, some SSO participants described having to work hard to join these conversations that they perceived were led by HSOs:

The lack of coordination among human services and health care workers, part of that is because if health care institutions are in charge of a meeting, then it's mandatory. If anyone else is [in charge] then it's optional and they don't come to the table. [SSO leader, Region B]

We have to work really hard to sit at the table. We have to work really hard to talk about how the work we do matters in health care. [SSO leader, Region B]

It's a challenge. I don't always think that people see a volunteer network as a significant stakeholder that should be at some of those tables and conversations. [SSO leader, Region B]

As in Region B, participants in Region C also described a CCO that was highly engaged in local efforts to drive multi-sector collaborations, but the CCO in Region C was typically identified as the funder of these efforts rather than a convener. For example:

The CCO has the largest influence because they have the most money. [HCO leader, Region C]

The CCO hold the purse strings for a lot of things. If we need extra money for a particular type of project, somebody has to go to them and talk about the project and then work to get funds earmarked for it. [HCO leader, Region C]

Instead, participants in Region C identified multiple organizations including an HSO and an SSO that were driving the region's collaboration efforts, and there was also a sense from some Region C participants that these organizations were vying with one another for local control, and exercising financial or political power to advance their own priorities. Some participants described this dynamic and the organizations explicitly, and others referred to it indirectly but without identifying the organizations involved, as these quotes illustrate:

[SSO] is the single largest organization, they are the center of a lot of things and they're everyone's first partnership, and if they're not going to be involved in something, it's kind of a huge hole because they do so much of the work in the community. Leaving them out is leaving out a huge piece. [HSO] is also a huge player because of their size, because they have their own money and then they also have access to resources to get other money. So, they have a huge say in what happens. [SSO leader, Region C]

[HSO] come into a community and they want the community to raise [money] for them to run their projects. A lot of the things that they've tried to put on with their initiative were already happening. [SSO leader, Region C]

You might have one community partner, for example, that's sort of a pillar in the community that goes, "we're not really involved in this. We don't see the value in

this and we want to create our own thing." And then, because they are such a pillar in the community, other partners might say, "okay, no, we don't really want to do that either," sort of following the lead of that entity. That can impact [collaborations], especially in smaller, more rural areas. [HSO leader, Region C]

This lack of agreement about who was leading local collaborative efforts in Region C appeared to coincide with a perception that the region was overtaxed with redundant community meetings led by various groups. This finding was supported by participants' references to meetings and groups indexed in the network map, which suggested that while participants were aware of a variety of coalitions and recurring community meetings, no one coalition was consistently identified by participants as a central hub where they convened for regional multi-sector collaborations. These quotes illustrate this point:

For me it's about time, because the health care partners are meeting a lot. There's a community health worker meeting. There's the one that [CCO] launched. Now there's this equity thing. There's also a [HSO] effort, and then there's an alcohol and tobacco group that meets over in [neighboring] county. It's about how much time do I have to go to their meetings. Not that they aren't useful, but I just have to figure out what's the most useful, because I could spend a lot of time every month in their meetings. [SSO leader, Region C]

Every CCO has just a ton of meetings, frankly. They really do. [HSO leader, Region C]

We often get asked to participate in things that are substantial time and resource commitments. We have to do a lot of negotiation about what we can really do as an organization. [SSO leader, Region C]

In contrast, Region D shared similarities with Region B in that participants consistently identified a CCO as one of the lead conveners of collaborations in the region and described the CCO positively. The participants in Region D did not describe local organizations vying for control over who would lead regional initiatives, and it was also

common for Region D participants to describe that they, and others in the region, had been doing work focused on SDoH for several years prior to the start of the AHC project.

As these participants stated:

There's a couple of people that work for the CCO that are very involved in the community, so I see them at a lot of the social service meetings. They serve on the early learning hub. We have a new board member now who works for the CCO. So they're very active in social services. [SSO leader, Region D]

In reality we've always been doing a lot of this kind of work, so [the AHC project] is not necessarily a lot different than what we were currently doing. Doing the surveys is different. [HSO leader, Region D]

We were talking about this last summer and having meetings at our county group about what [safety net resources] exist, how do we put together a directory of these things so that people know about it? [HSO leader, Region D]

Region D participants reported being well connected to other organizations in the region via a multi-sector coalition focused on homelessness and other collaborative workgroups focused on specific topic areas such as emergency department discharges, while CCO meetings were also described as a hub for the purpose of establishing regional goals and distributing resources to community programs. Network mapping of Region D participants' references to these meetings in interviews confirmed that a homelessness coalition and health council meetings were consistently identified across multiple participants. In contrast to Region C, Region D participants did not describe redundancy in these meetings but described them as important for focusing regional leaders' attention on SDoH through regional planning, as these quotes illustrate:

I don't find [collaboration] that hard. I think one of the things we focus on here is our regional health improvement plan. A lot of the goals that we're looking at with [the AHC] project are also part of our regional health improvement plan. So people have shared goals around things. [HSO leader, Region D]

We created our regional health improvement plan. We really focused on social determinants of health in the last four years. We were already looking at how to get out of siloes and work together more. That's been a trend here. [HSO leader, Region D]

There was evidence that the individual participants in Region D were also well connected to one another on a personal basis in addition to their connections through organizations and coalitions, as these quotes illustrate:

People know that I work here and so they use that as an opportunity to ask questions. I also was bowling for a while. I dropped out the last couple of years because things got kind of busy around here, but some of the people I bowled with were patients. So I was out in the community in that sense and they knew me as part of the practice. [HSO leader, Region D]

The person who drives the most conversation isn't even doing it from an organizational standpoint. [Individual], far and away, is the person who drives the conversation about social determinants of health and collaboration. She definitely has the best grasp on those systems and how they can be used for good and how they can make so much of a difference through collaborations. Even though she isn't really part of an organization, she's still who I'm asking those questions to when I'm trying to improve those connections. [SSO leader, Region D]

Competition and Perceptions of Others' Motives. Participants across regions described varying levels of conflict. Some of Region A's participants, who had described their region as a place that struggled to collaborate, spoke openly about a sense that organizations were in competition with one another for funding, and that achieving efficiency for the system as a whole might require individual organizations to lose market share or give something up, which was undesirable. These participants stated:

The competition for funds ultimately is what it is. So whether that's competition for patients, competition for providing services. When there is a change in focus, there's a change in funding streams, where other funding streams kind of die off. Organizations may be vying for all of that. And obviously there's a saturation point around the number of services and folks that need those services. So that's

probably the biggest challenge in working together is that competition. [HSO leader, Region A]

To me, it's money. In a perfect world, everything would be free and open and we'd all support each other. And I think that's an admirable goal, that we should become more collaborative. But at the end of the day, the way our society works is it's transactional. [HSO leader, Region A]

Some of the Region A conflict appeared to be related to negative perceptions of potential partner organizations as acting in their own interests or being unwilling to enter into partnerships. These Region A participants stated:

So the CCO, or the county, or [SSO] for example, have less desire to interact with us because they feel like we have the largest resource pools, so we can figure it out. [HSO leader, Region A]

The local for-profit hospital makes decisions in isolation that will affect the CCO, but just sort of does it secretly and with their own self-interest and not with their CCO hat on. Their leader is not empowered to be fully locally oriented. He's got shareholders and there are other pressures that drive that. [SSO leader, Region A]

In contrast, interviews with participants from Region B were noteworthy for their general lack of reference to competition among organizations for resources or claiming credit for work done in partnership. While some Region B participants acknowledged that these pressures existed, they also downplayed the impact of competition on the region's ability to collaborate. For example:

[Competition] is definitely is a factor, but what I can say is that for the people on the ground doing the work, collaboration is much more impactful than the competition. I think competition happens at higher levels, but when it's really around "how do we serve our community?" we have worked closely. [HCO leader, Region B]

Region B participants generally shared positive perceptions of the other Region B organizations. One notable difference in Region B was in how participants often

identified specific individuals by name or by role, when discussing their work with other organizations in the community. The nature of relationships among organizations was often considered in the context of these personal relationships, as evidenced by these participant quotes:

They're just a pivotal organization in [the county], uniting the work people are doing. Their executive director is one of my biggest heroes in the history of heroes. [SSO leader, Region B]

One thing that has been really helpful [with HSO] is we are working with a champion of this type of work. She has done a really great job of bringing people in house. [SSO leader, Region B]

We're just really understaffed. If we had more time to do outreach in that area, I can see [HSO] being open to it. Particularly [individual] at [HSO]. [SSO leader, Region B]

Region C participants described their region as struggling to collaborate despite many meetings and coalitions where they had opportunities to do so. In contrast to Region B, where participants described lower levels of competition and conflict among organizations, Region C's participants described conflict related to power struggles over regional funding priorities and competition for limited resources, as these quotes illustrate:

[HSO initiative] takes a lot of money out of the community that could be used for something useful. [SSO leader, Region C]

Here, there's competition between [HSO] and [HSO]. They kind of butt heads. [SSO leader, Region C]

It was a pretty typical nonprofit debacle. [HSO] announced a grant to address social determinants of health. We were interested in that and asked whether the project had to serve their recipients exclusively. Their answer was no, so we submitted a grant. A couple of other organizations did too. Then [HSO] came back and said, "actually, we won't consider these." So people were frustrated and

expressed that frustration. Then there was this offer that, "well, we could give you a really small grant to do a small part of the project." [SSO leader, Region C]

It was not uncommon for participants in Region C to express frustration about, or lack of trust in, other organizations in the community, as evidenced by these quotes:

They aren't very good listeners, which maybe is a problem across the board. Sometimes you feel like you're beating your head against the wall. [SSO leader, Region C]

[SSO] is just kind of notorious for being disengaged in this area. They're just kind of known as not a very good [SSO]. I'm not sure if it's their leadership or why exactly that is. Most agencies know that they're just kind of disengaged from any sort of community collaboration. They're usually the ones missing. [SSO leader, Region C]

We're always reaching out trying to make sure that our referrals actually go someplace, but ... I understand [our program], because they're here and they're with us. But some of the other organizations, I don't know as well. [HSO leader, Region C]

Generally, participants in Region D described positive working relationships with one another and a lack of competitive dynamics across the region as a whole, as these quotes illustrate:

Public health, [individual]'s group, we know these folks. A lot of them know us on a first name basis and we get along really well. We refer back and forth and we have a good old time because they're not trying to be a big thing. They're just like us. [HSO leader, Region D]

We have really good relationships, and I would say that the organizations or partners that we work with on a regular basis, I wouldn't have any concern about. [SSO leader, Region D]

So far [our partnerships] have all gone really, super well. Eventually one will be a more difficult relationship, but you work through those things. [SSO leader, Region D]

Despite these general quotes about positive experiences with collaborations, there was evidence of conflict in the region related to working with one specific HSO, which was described negatively by all but one participant. This HSO was described as antagonistic and difficult to work with, which was explained as creating a competitive dynamic within the region that would not exist otherwise. These Region D participants stated:

Rather than trying to see if it could be a relationship between them and our community [HSO] to make it work, [HSO] felt the only way to make it work was to take over. I don't know that that had to occur. [HSO leader, Region D]

I sit on an advisory board of a small volunteer-run nonprofit that was created in response to improper discharge out of [HSO] which had resulted in a death. [SSO leader, Region D]

I have some great relationships with [HSO], but it's the folks that are doing direct service that get it. They are ground level enough to see what the needs look like and see how policies help or hinder making positive change. They're fighting internally up the chain of command. There's a lot of territorialism. [SSO leader, Region D]

At the same time, some Region D participants noted that due to the HSO's size and relative influence in the region, it was important to continue efforts to work with them, and affiliation with the HSO could bring legitimacy or opportunities for funding:

[HSO] also has a pretty robust foundation that gives that grants to different social services. So, I see them a lot and they do fund a lot of different things here and there. [SSO leader, Region D]

It's great for me to have [HSO] be at the table. Our behemoth [HSO] in [Region D]. It's great for me to have them at the table with me, a little nonprofit director, with her staff of three people. That's fantastic for us to open those doors. [SSO leader, Region D]

In summary, variation was observed across the four AHC regions in how participants described the local task structure in which collaborations occurred. Regions A and C described their regions as lacking clear local leadership for multi-sector collaborations, either because no organization clearly held a role as convener or because multiple organizations were vying to do so, yielding redundant efforts. Region A and C participants also described struggling to find opportunities to connect with one another; in Region A participants could not identify community meetings where they could connect, and in Region C they identified competing and redundant meetings, struggling to know which ones to prioritize with limited time.

In contrast, participants in Regions B and D described a central role of the CCO as a convener of multi-sector collaborations and consistently identified a small number of regional meetings where organizations connected with one another. Participants in Regions B and D less often described being in competition with one another for resources and generally described success reaching agreement on shared regional priorities for addressing SDoH; when conflict was described in Regions B and D it more often took the form of perceived power differences between large and small organizations rather than mistrust of partners' motives.

Summary of Regional Variation

The variation observed across regions in participants' identities, perceptions of the situation, and task structures, are summarized in Table 4.3 below.

Table 4.3: Variation in Themes by Region

Themes	Region A	Region B	Region C	Region D
Personal and Organizational Ties to the Region [Identity]	<ul style="list-style-type: none"> • Organizations serve multiple regions • Participants had weak ties to the region 	<ul style="list-style-type: none"> • Organizations focused on one region • Participants had strong ties to the region 	<ul style="list-style-type: none"> • Organizations serve multiple regions • Participants had weak ties to region 	<ul style="list-style-type: none"> • Organizations focused on one region • Participants had strong ties to the region
Collaboration as Part of Regional Identity [Identity]	<ul style="list-style-type: none"> • Participants described the region as not collaborative • Participants look for external leadership 	<ul style="list-style-type: none"> • Participants described the region as highly collaborative • Participants look for local leadership 	<ul style="list-style-type: none"> • Participants described the region as not collaborative • Participants look for external leadership 	<ul style="list-style-type: none"> • Participants described region as moderately collaborative • Participants look for local leadership
Problematic People versus Problematic Systems and Societies [Perception]	<ul style="list-style-type: none"> • People as problems • Lack of internal buy-in • Lack of trust in partner motives 	<ul style="list-style-type: none"> • Systems as problems • Lack of infrastructure • Rising social needs 	<ul style="list-style-type: none"> • People as problems • Resistance to shared goals • Lack of trust in partner motives 	<ul style="list-style-type: none"> • Systems as problems • Lack of service capacity • Rising social needs
Clarity of Purpose and Value Proposition for Collaboration [Perception]	<ul style="list-style-type: none"> • Weak clarity of purpose for collaborations • Emphasis on costs and sustainability 	<ul style="list-style-type: none"> • Strong clarity of purpose for collaborations • Emphasis on value of data for planning 	<ul style="list-style-type: none"> • Weak clarity of purpose for collaborations • Emphasis on raising awareness of programs 	<ul style="list-style-type: none"> • Strong clarity of purpose for collaborations • Emphasis on program capacity
Characteristics of Regional Conveners and Visibility of Settings for Collaboration [Task Structure]	<ul style="list-style-type: none"> • Absent regional leadership • Weak CCO role and engagement • Low visibility of regional meetings and partners 	<ul style="list-style-type: none"> • Uncontested regional leadership • Strong CCO role as convener • High visibility of meetings but with barriers to joining 	<ul style="list-style-type: none"> • Contested regional leadership • Moderate CCO engagement but not as convener • High visibility of meetings but with duplication 	<ul style="list-style-type: none"> • Uncontested regional leadership • Strong CCO role as convener • High visibility of meetings and partners
Competition for Resources and Perception of Others' Motives [Task Structure]	<ul style="list-style-type: none"> • Strong competition for resources • Organizations perceived to act in self-interest 	<ul style="list-style-type: none"> • Weak competition for resources • Organizations perceived to act collaboratively 	<ul style="list-style-type: none"> • Strong competition for resources • Organizations perceived to act in self-interest 	<ul style="list-style-type: none"> • Weak competition for resources • Organizations act collaboratively with key exceptions

While each community was unique in terms of the types of organizations that participated in this research, a comparison of themes across the four AHC regions revealed similarities between Regions A and C, and between Regions B and D. With respect to identity, the participants from Regions A and C reported weaker personal ties to their regions than the participants in Regions B and D, described their organizations as being based outside the region (sometimes resulting in conflicting priorities between local staff and leadership based elsewhere), and were more likely to take a critical stance on their region's success with multi-sector collaborations to address social determinants of health.

When asked to articulate the problems that multi-sector collaborations (such as the AHC project) were intended to address, participants in Regions A and C tended to express frustration with the attitudes or behaviors of people within other organizations in their region and viewed the purpose of multi-sector collaborations as overcoming these differences. Region A and C participants more often struggled to articulate the value of multi-sector collaborations (and the AHC project) for their organization or region and weighed the costs of collaborative efforts against the benefits for their own programs or clients. In contrast, the participants in Regions B and D described the purpose of multi-sector collaborations as addressing rising inequality or unmet needs in their community, perceiving value for the community as a whole in obtaining data for planning purposes or for better allocating community resources.

The four regions varied in how participants described the local context or task structure for collaborations, with Regions A and C describing their regions as competing

for resources and lacking shared understanding across organizations about who (if anyone) was leading regional efforts to address SDoH; these participants sometimes described looking outside the community for leadership on multi-sector collaborations. In contrast, participants in Regions B and D more consistently identified certain organizations as leading local efforts and did not describe organizations in the region vying with one another for leadership of these efforts. There appeared to be a stronger shared understanding across Region B and D participants about which local meetings and coalitions were central to the region's efforts to address SDoH. When conflict and competition were described in Regions B and D, it was not described as preventing organizations in the region from working together but rather as a point of tension within existing partnerships.

Conclusion

This chapter presented results of the analysis of the surveys, interviews, network maps and documents collected for this research, organized in two ways: first by segmenting participants according to whether they represented health or social service organizations, and second, by segmenting participants according to the four AHC regions they served. Data were examined and compared through the lens of the Appropriateness Framework domains (Weber, Kopelman and Messick, 2004), revealing differences in how participants described 1) collaboration risks to their identity, 2) risks related to perceived problems and solutions, and 3) risks related to the task structure or context in which collaboration occurred.

The comparison of perspectives on collaboration risk by sector revealed that with respect to identity, HSO and SSO leaders' personal and organizational motives to collaborate, perceived stakeholders, and responsibilities, varied across sector lines. With respect to perception of the situation, HSO and SSO leaders also possessed different views of the problems that multi-sector collaborations ought to address, the value of multi-sector collaborations generally and referral networks specifically, and the benefits of organizational change. With respect to the task structure of collaboration, HSO and SSO leaders also weighed different technical and social considerations in choosing whether to enter their organization into multi-sector partnerships.

These similarities and differences reflected cross-cutting themes across all four AHC regions; however, further segmentation of participants revealed variations in each AHC region's identity and collaborative structure that were unique to their specific communities. With respect to identity, participants from the four regions differed in the ways they each characterized their region and their connection to it. Regarding perceptions of the situation, participants across regions exhibited differences in whether and how they perceived multi-sector collaborations to be beneficial to their organization's or region's goals. With respect to task structure, participants varied in how they described the other organizations in the region that they perceived to be potential partners in multi-sector efforts to address SDoH; and the ways they described meeting and working with these organizations.

Chapter Five presents a synthesis and discussion of these findings, their connections to prior research, and their relevance for multi-sector collaborations to

address social determinants of health. This discussion is organized by the four aims of this study: to understand (Aim 1) and compare (Aim 2) health and social service leaders' perceptions of risk in multi-sector partnerships, to explore how these risk perceptions relate to leaders' decision making about collaborations (Aim 3), and to articulate the implications for policy and practice (Aim 4). Chapter Six summarizes the overarching conclusions and limitations of this research and recommendations for future study.

Chapter Five – Discussion

Note: The study results presented in this Chapter are published in:

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Overview

Despite widespread calls to action for health and social service organizations to strategically align their efforts, few examples exist so far of communities where health and social service organizations have seemingly achieved this multi-sector alignment. The literature summarized in Chapter Two positioned this research on multi-sector partnerships within a larger body of work related to why fragmentation occurs between organizations and sectors, and how organizations overcome fragmentation through collective action. Organizations operate within evolving and uncertain policy environments that create both explicit and implicit incentives to compete or collaborate, and organizational leaders must weigh myriad factors, including perceived risks, when deciding how their organizations will respond to these incentives.

Chapter Four presented detailed findings from this research about participants' collaboration risk perceptions organized by the domains of the Appropriateness Framework: 1) identity, 2) perception of the situation, and 3) task structure (Weber, Kopelman and Messick, 2004). Participants' perspectives about collaboration risk were compared first by sector (see Chapter Four, Table 4.2), and then by geographic region

(see Chapter Four, Table 4.3), drawing from multiple data sources including surveys, network maps, interviews and documents.

This chapter synthesizes the Chapter Four findings from all data sources, and identifies where these findings relate to, and extend, the literature reviewed in Chapter Two. The chapter is organized to address the four research aims of this study:

1. characterize the organizational risks of strategic alignment that are perceived by partners in a community for health, as well as the perceived causes or sources of those risks;
2. compare the similarities and differences in how various stakeholders perceive organizational risks of strategic alignment;
3. explore how perceived risks shape stakeholder negotiations, acting as incentives (or disincentives) for organizations to strategically align; and
4. discuss the implications of these perceptions for policy or systems changes to incentivize organizational strategic alignment within communities for health.

Aims One and Two: Organizational Risks of Strategic Alignment

Aims One and Two of this research characterized and compared the organizational risks of strategic alignment perceived by partners in a community for health. To address Aims One and Two, this section synthesizes and discusses key findings regarding health and social sector leaders' perceptions of collaboration risk, highlighting similarities and differences in perspectives across sectors within each of the three framework domains.

Identity

As presented in Chapter Four, while health and human service sector participants described personal and organizational values and motives driving their work that were superficially similar, including being of service to those in need, they also exhibited different understandings of what it meant to express these values in their daily work.

These differences were important because health and social service leaders alike viewed their personal and organizational success through the lens of these values and priorities, and perceived that collaborating in ways that conflicted with these values and priorities represented a risk to their personal and organizational legitimacy.

Health service organization (HSO) leaders described their work to address social determinants of health through multi-sector collaboration as occurring within the larger context of the health sector, moving toward new models for population health management (Eggleston and Finkelstein, 2014). For HSO leaders, being of service to others and acting in ways that were consistent with one's values meant demonstrating measurable outcomes of one's work, such as improving the health status of a population, or increasing the number of individuals served by the organization, which reflected the health sector's increasing focus in recent years on measurement and indicators of performance (Martin, Nelson, Rakover & Chase, 2016).

Evidence of one's success, personally or organizationally, was further identified by HSO leaders as being a change agent or leader by helping to advance overarching health sector goals such as the transition toward alternative payment models ("Striving Toward a Culture of Health", 2017). HSO leaders weighed the value or risk of multi-sector collaboration through this lens of credibility and legitimacy; partnerships that were deemed likely to bolster an organization's reputation as a leader in the field on population health issues, or that would help it achieve performance measures such as improved health outcomes or greater cost savings, were enthusiastically pursued, whereas partnerships that may not result in measurable performance improvements, or could

undermine existing performance by pulling resources away from other activities, were characterized as risky and less appealing to HSOs.

In contrast, social service organization (SSO) leaders did not describe efforts to partner with HSOs as occurring within a larger context of the social service sector as a whole embracing health system partnerships, but rather in a sociopolitical environment that was described as increasingly hostile to their work and the vulnerable populations they served (Rainie, Keeter and Perrin, 2019). SSO leaders' perspectives suggested that they more often viewed "being of service to others" as acts of resistance within existing service delivery systems on behalf of those who were most vulnerable within a larger population, giving choice or agency to individuals who otherwise lacked it within existing systems, and working to represent forgotten perspectives or populations in community-level conversations about health and wellbeing. The emphasis on client autonomy as a core professional value within social work is well documented in the literature (Horne, 2018). In contrast to the HSO emphasis on population health management and accountability for performance, SSO credibility or legitimacy seemed to derive from "speaking truth to power" by specifically avoiding allying oneself with organizations perceived to be profit-motivated or representing dominant interests, and instead using one's position to call attention to the ways that existing systems of care were inadequate or harmful for certain individuals.

This SSO expression of service through resistance meant that collaboration was described by SSO leaders as more valuable when it involved allying with other organizations whose missions were tailored toward similar underserved groups (such as

federally qualified health centers or community mental health agencies). It appears that these kinds of partnerships did not risk the perception that an SSO was allying itself with dominant or for-profit interests for the sake of funding. As well, partnership opportunities that brought visibility to an SSO's programs or priority issues within larger community groups appeared to be more easily justifiable as a form of social justice advocacy, while collaboration was perceived as a risk to SSO legitimacy or identity if it meant endorsing community priorities (such as through a community health improvement plan) that did not include one's priority population or issue area as a central focus.

This research also revealed differences in how SSO and HSO leaders appeared to be oriented toward competition with other organizations. For SSOs, differentiating one's organization and mission from other SSOs in the community by avoiding duplication of programs and services appeared to be a strategic mechanism for avoiding competition (Oliver, 1991). SSO leaders appeared particularly oriented toward using multi-sector collaboration as an opportunity to identify and eliminate redundancy in the social service delivery networks in their region. In turn, SSO leaders perceived threats when others (whether SSO or HSO) might duplicate their own efforts or take credit for outcomes the SSO helped produce.

For HSO leaders, in contrast, differentiating their organizations from other HSOs in their community appeared to be less of a strategic imperative; rather than avoiding competition, they tended to describe competition as an inevitable aspect of their work, and emphasized performance management as a way to gain strategic advantage over competitors. This may have explained why HSOs' motivation to collaborate across sector

lines was less oriented toward reducing duplication with other HSOs and more focused on aligning one's services with community priorities to demonstrate value, and identify and fill gaps in programs. These differences in HSO and SSO leaders' orientations to competition may also reflect differences in social or professional norms within their respective sectors.

Finally, it was apparent that organizational leaders who strongly identified as members of their specific community (rather than residing elsewhere or being new to the region) also viewed their region as more inherently collaborative, in some cases describing collaboration as part of the community's collective identity rather than the result of any specific effort such as the AHC project. In turn, this belief appeared to be related to the sense of personal responsibility that participants felt for behaving collaboratively toward other organizations in the region. This difference was apparent even though participants who worked in larger organizations serving multiple regions also espoused similar personal values of being of service and working together.

It may be that the differences in their organizations' size, scope and service delivery area influenced how organizational leaders weighed the importance of aligning their efforts with local partners and priorities in the AHC regions, with some leaders instead perceiving obligations to align their efforts with different groups of stakeholders. Prior research has suggested that within collective action dilemmas, competitive behaviors may vary based on whether an actor perceives a potential partner to belong to the same groups or communities (Kollock, 1998; Exworthy, 1998). For the organizations in this research, regional identity (i.e. within-group status as a member of the geographic

community) appeared to be more important than sector identity in determining whether individuals were motivated to act collaboratively toward one another.

Perception of the Situation

There were overarching similarities in the ways that HSO and SSO leaders characterized the problems that they perceived multi-sector collaboration was intended to address (Bacchi, 2009); specifically, the service delivery networks in their region were not meeting the needs of the community and when organizations all operated according to their individual goals and priorities, the result was both gaps in, and duplication of, services. For HSO leaders, the risk of maintaining the status quo of disconnected or fragmented work was that their organizations would increasingly struggle to remain competitive within a health sector that was moving toward rigorous emphasis on outcome-based performance management and payment models (Institute of Medicine, 2011), or that the organization would lose support of key stakeholders such as their regions' CCOs as those organizations adopted social determinants of health as strategic priorities (Oregon Health Policy Board, 2018). For SSO leaders, the risk of doing nothing to address coordination challenges was the potential that HSOs would pursue activities or strategic priorities that affected SSOs without their input, or that SSOs would miss opportunities to advocate that HSOs provide funding for social services in the region. SSO leaders described a sense of being left behind or left out of important community conversations if they did not "fight to be at the table" in regional conversations about health priorities.

Notably, despite the widespread references by HSO and SSO leaders to organizations operating in silos and lacking coordination, participants in this research also implied that referral networks were not, by themselves, examples of multi-sector partnerships, and were not adequate to address lack of coordination in the absence of additional efforts to build inter-organizational relationships. This finding revealed an assumption held by some HSO and SSO leaders that the root of coordination challenges was not necessarily that their clients lacked understanding of services in the community or the ability to access these services, but rather that their fellow service providers lacked understanding of one another. The risks of uncoordinated efforts were described by HSO and SSO leaders alike as other service providers not understanding their operations or models of care, making inappropriate partnership requests that organizations could not fulfill without risk of reputational damage or noncompliance with funder requirements, misrepresenting to clients what services or assistance might be available following a referral, or creating new programs or initiatives that duplicated existing efforts.

This finding is noteworthy because there is potential for misalignment between the objectives and methods of multi-sector partnership projects such as AHC; while the purpose of this type of project is sometimes described as “strategic alignment” of organizations (as is the case with the AHC project), the mechanisms used (screening, referral and navigation support) target individual clients in order to increase their ability to navigate among organizations and access services across multiple locations (Nuno-Solinis, et al., 2019). This research suggests that some HSO and SSO leaders may be ambivalent about this solution framing if they do not perceive the methods to be aligned

with the problem they are trying to address: that the workforce within HSO and SSO organizations do not understand, and are not connected to, one another (Bacchi, 2009).

This may be related to another finding from this research, that HSO and SSO leaders alike sometimes perceived difficulty building buy-in for projects such as AHC with their internal stakeholders, including staff, clinicians and board members. This challenge was often described in the context of staff or leadership skepticism about the accuracy or efficacy of referrals as an approach to addressing social determinants of health. When participants described stronger levels of motivation or acceptance of these kinds of projects from internal stakeholders, they attributed this to stakeholders perceiving value in raising awareness of one another's work, or collecting screening data for fundraising, advocacy or regional planning purposes, rather than value in referring individual clients to resources they would not otherwise have been able to access.

By extension, when describing the AHC project specifically, the principal risk of failure articulated by HSO leaders was the possibility that they would invest time and resources to implement the screening and referral workflows but would not generate sufficient data to be able to draw meaningful conclusions from the work. There was very little discussion among HSO leaders about the risk that the AHC project would not help cultivate relationships with SSOs, raise visibility of their work with SSO partners, or result in more integrated delivery of services, because they did not generally describe these as goals of the project. When SSOs described the risk of failure for projects such as AHC, it was in terms of poor referral quality – providing incorrect information, providing duplicative screenings and referrals, or giving clients information about services that they

were already aware of. Similar to HSOs, they rarely described the success or failure of projects such as AHC in terms of developing better relationships or more integrated models of care across sector lines.

Task Structure

This research revealed similarities and differences in how HSO and SSO leaders perceived risk in the task structure of collaboration, which Weber, Kopelman and Messick (2004) defined as both the task itself, as well as the social context in which the task must be completed. These findings are consistent with literature regarding organizational behavior and social dilemmas that was described in Chapter Two. These associations between the research findings and prior literature are discussed below.

Organizational Context and Resource Dependence. This research confirmed that organizational context is an important factor in how leaders perceive risk in multi-sector partnerships, including the organization's resource dependencies and constraints (Pfeffer and Salancik, 1978; Williamson, 2002). Both HSO and SSO leaders considered their options for collaboration in the context of their specific resource dependencies; while workforce issues were the primary resource constraint described by HSO leaders, program and service funding constraints were primary considerations for SSO leaders.

Within HSOs, resource constraints manifested as leaders frequently describing staff turnover as a limiting factor in their ability to engage in multi-sector partnerships. In addition to grappling with ongoing cycles of hiring and losing staff, and inability to fill vacant positions for long periods of time, HSO leaders also weighed the impact of any new collaborative activities on staff morale, specifically because new efforts risked

frustrating or burning out employees. The initial training requirements of a project such as AHC were also considered because of the perceived high likelihood that organizations would need to repeat trainings over time due to high levels of staff turnover. These findings are consistent with documented widespread labor shortages within the health sector over the past decade that are projected to continue for the foreseeable future (“Health Workforce Projections”, 2019).

In contrast, SSO leaders described funding for services as the primary resource constraint that limited their ability to engage in multi-sector partnerships. SSO leaders carefully weighed perceived sustainability of new opportunities and often spoke of the concern that staff positions or programs would need to be eliminated if they lacked an ongoing and renewable source of funding. Despite the perceived heavy burden of participating in community meetings and alliances, SSOs described connecting with HSOs via community meetings as a way to build relationships that might lead to new funding opportunities in the future. SSO leaders saw new HSO partnerships as an opportunity to move toward fee-for-service reimbursements that were perceived as more sustainable sources of revenue than grants or charitable contributions from the community (in contrast to HSO leaders, who described their field as a whole as moving away from fee-for-service payment models). SSO leaders also described partnerships with HSOs as signaling to others in the community that the SSO was credible and legitimate. SSO leaders’ perceptions of funding scarcity are consistent with trends documenting that at the time of this research, public funding and charitable donations had substantially decreased following federal tax reform in 2018 (Indiana University Lilly

School of Philanthropy, 2019). Despite their desire to obtain new funding through HSO partnerships, SSO leaders rarely described existing financial support from HSOs (including, notably, from their region's CCOs).

Generally, HSO leaders also described being able to directly advocate or negotiate with their funders in a way that SSO leaders did not. Among HSOs, this manifested as leaders describing how their organization aligned its efforts with CCO priorities because the HSO had existing financial relationships with CCOs to provide services to their members. HSOs saw multi-sector collaboration as a way to signal support for new CCO 2.0 requirements to address social determinants of health and cost containment (Oregon Health Policy Board, 2018), while projects such as AHC represented a way to generate screening data that could be used to advocate with the CCOs for funding new initiatives.

In contrast, SSO leaders viewed multi-sector partnerships through the lens of the categorical restrictions attached to federal funding streams on which they relied, such as funding for Area Agencies on Aging through the Older Americans Act (42 U.S.C., §3001), housing authorities through Housing and Urban Development (42 U.S.C., §1437f), domestic violence programs received through the Violence Against Women Act (42 C.F.R. §13701-14040; expired at the time of this research), or volunteer-run programs received through the Corporation for National and Community Service (42 U.S.C. §12501). In these cases, SSO leaders considered whether a partnership risked their compliance with categorical restrictions on who could be served by these funding streams, because they could not easily change these funders' priorities or requirements by directly appealing to the funder ("Federal Low Income Programs", 2017). Organizations

that were perceived to already operate under similar constraints or serve highly aligned populations were described by SSO leaders as being easier to partner with.

Regional Context and Social Dilemmas. This research confirmed that the external environment is an important factor in how leaders perceive collaborative risk, including both the regional social structure that exists among people and organizations, and the technical structure of meetings and alliances where collaboration occurs (Kollock, 1998; Weber, Kopelman and Messick, 2004). Both HSO and SSO leaders considered the “transaction costs” of engaging in new collaborations in their regions (Robinson, 1994; Williamson, 2002), including the time involved in attending meetings and developing new relationships, the perceived trustworthiness of potential partners, and the sources of uncertainty.

Both HSO and SSO participants pointed to community health improvement plans (CHIPs) as a mechanism by which organizations could adopt shared goals for working in multi-sector partnerships, and as an important tool for organizing a region’s efforts to address social determinants of health (Stoto, Klaiman, and Davis, 2018). The way that communities leveraged regional meetings and planning processes appeared to have implications for how organizational leaders perceived the risks of projects such as AHC. The comparison of the four AHC regions in Chapter Four revealed that, in some regions, there appeared to be a shared understanding among participants about where and how HSO and SSO organizations could connect with one another and contribute to regional planning conversations; when this local meeting structure was highly visible and familiar to participants (as in regions B, C and D), they cited it as the social structure through

which multi-sector partnerships to address social determinants of health should occur.

Likewise, in some regions there appeared to also be a shared understanding that a specific organization or group (such as the CCO) was the lead convener of multi-sector partnerships (as in regions B and D); when multiple organizations were vying for this role (as in region C), it resulted in perceived duplication of meetings, confusion about how participants should prioritize their time, and concerns about alienating partners or funders by being perceived as endorsing certain efforts over others.

It is possible that regional meetings and planning processes help to facilitate multi-sector partnerships by enhancing the “searchability” of the network of HSOs and SSOs in a community, increasing organizational leaders’ awareness of one another (which was discussed as a key coordination challenge above) and making it easier for organizational leaders to identify potential partners outside their own sector (Watts, Dodds and Newman, 2002). In this way, regional meeting structures may help decrease the structural complexity for a community of entering into new partnerships (Williams, 2002); this benefit may also be undermined or negated when there are multiple competing efforts in a region (as was seen in Region C).

This clarity about regional meeting structures may partially offset the perceived costs of forming partnerships, but it did not necessarily appear to enhance the perceived trustworthiness of potential cross-sector partners in the AHC regions. HSO and SSO leaders appeared to look for, and value, different signals of trustworthiness from their potential community partners. Among HSOs, leaders looked for others’ willingness to participate in meetings, openly share what their organizational priorities were, and

consistency in following through on commitments (including meeting performance metrics). Among SSO leaders, trustworthiness of partners was gauged by the visibility and accessibility of an organization's senior leadership (i.e. being represented in community meetings by people with decision making authority for the organization), taking time to learn an organization's values and approach to providing services, and sharing resources while avoiding undermining others' fundraising efforts.

These differences may reflect differing norms of behavior that exist within the health and social sectors and point to specific tensions that may arise when HSO and SSO organizations described trying to work together (Kadushin, et al., 2005). For example, among HSO leaders it was important to demonstrate accountability to their partners by establishing clear performance metrics and methods of measuring their work and relying on these performance measures to hold themselves and others accountable. They held similar expectations of their community partners. In contrast, SSO leaders were skeptical of this reliance on performance metrics for accountability because they perceived that it was not a substitute for organizational leaders understanding one another's work. In the absence of direct relationships with an HSO's leadership, an SSO would not be able to hold an HSO accountable if it did not uphold its part of an agreement. Reliance on performance measures or reporting structures in lieu of relationships was perceived by some SSO leaders as a show of bad faith by HSOs that sought to shift the burden of outcome-based payments to SSOs without sharing the costs of doing the work. This finding echoes other research suggesting that over the past several decades, performance and accountability movements such as New Public Management have largely transferred

the cost of developing and maintaining new accountability structures to small social service agencies at the same time that public financial support for their programs has fallen (Never and deLeon, 2017).

As was described previously, this research also revealed some cognitive dissonance among participants about the AHC project's use of screening and referral networks as a mechanism to encourage cross-sector collaboration between HSOs and SSOs. Some participants perceived value in more closely aligning efforts such as AHC with the needs assessment that supported the selection of regional CHIP priorities, in order to ensure the data collected through screening activities were explicitly linked to decision making about investments in population health promotion. This was identified as one way to ensure that projects such as AHC informed system change even when they may not result in addressing every client's unmet social needs.

However, this research also revealed that CHIPs are emerging as one primary way that political power is exercised among health and social service organizations in a community (Watson and Foster-Fishman, 2013). While HSOs tended to view CHIPs as an opportunity to bring their organization's programs or services into alignment with community needs and justify those changes in the context of larger regional priorities, SSOs sometimes perceived that CHIPs represented a threat to their organization if their target population or issues were not reflected in the region's collective agenda. Examples of this dynamic emerged within the AHC communities; in multiple cases, when a region had adopted CHIP priorities focused on children, the region's organizations serving seniors perceived this as a threat to their ability to advocate or raise resources, and their

leaders were less motivated to participate in multi-sector efforts as a result. In other cases, participants from organizations with highly marginalized service populations, such as domestic violence survivors or undocumented immigrants, perceived that the region had opted not to elevate these priorities because they were controversial or socially stigmatized.

These findings are consistent with Social Construction Theory (Schneider & Ingram, 1993) in that U.S. welfare policies have constructed social groups (and programs to serve them) through the use of categorical eligibility for certain types of publicly funded services; even though many of the participants served by these programs may possess multiple identities or be eligible for services across multiple programs, the categorical identities that have been institutionalized through federal funding streams create political tensions and reputational risks of collaboration among the organizations that rely on these revenues (Benach, et al., 2011; Schneider, Ingram, & deLeon, 2014). In this way, regional multi-sector planning processes such as CHIPs may either mitigate or risk magnifying the marginalization of certain groups of people, depending upon how these inter-organizational processes are enacted (Stoto, Klaiman, and Davis, 2018). Recommendations are presented later in this chapter for proactively addressing how the adoption of regional priorities will necessarily shift attention away from issues and populations that are not central to a group's collective agenda.

Summary

In summary, the investigation of Aims One and Two of this research revealed collaboration risks in multi-sector partnerships that are summarized in Table 5.1. Health

and social sector leaders viewed their organizational legitimacy and success through different lenses, leading to different perceptions about the risks to their credibility that cross-sector collaboration or strategic alignment could pose. Leaders across sectors shared misgivings about whether screening and referral interventions were the right solution to address unmet social needs; despite this skepticism, both HSO and SSO leaders feared that failing to engage in efforts such as AHC risked their organizations being “left behind” or not included in important sector-wide conversations.

Differences were revealed in the primary resource constraint that appeared to drive HSO and SSO leaders’ decisions, with HSO leaders worrying about the effect of collaboration on workforce constraints and staff morale, and SSO leaders worrying about whether collaboration would require new activities or increase demand on services without yielding new or sustainable funding. Leaders across sectors perceived value in an organization such as a CCO serving as a regional convener, in order to streamline the identification of partners and coordination of efforts; however, this value was lost when multiple organizations competed for the role of convener.

HSOs assessed the trustworthiness of other organizations according to measures of accountability and performance, such as providing data to demonstrate effectiveness; SSOs relied much more on interpersonal relationships as a measure of partner trustworthiness, including the willingness to participate in group activities or make senior leaders accessible for relationship building over time. Organizational leaders across sectors shared a common perception that large organizations sometimes faced conflicting priorities with different groups of stakeholders.

Table 5.1: Summary - Risks of Multi-Sector Health Partnerships

Risk	Health Service Organizations	Human Service Organizations
Threats to Credibility [Identity]	<ul style="list-style-type: none"> • Credibility derives from improving health status. Success is evident through performance measures. Partnerships that undermine performance measures are a risk to legitimacy. • Competition is navigated by improving performance to gain strategic advantage. • Leadership is demonstrated by advancing sector goals. Strategic alignment with broad sector goals enhances legitimacy. 	<ul style="list-style-type: none"> • Credibility derives from providing services to people who are underserved by mainstream society/systems. Partnerships that expand focus to other populations are a risk to legitimacy. • Competition is navigated by narrowing focus or mission to avoid duplicating efforts of other organizations. • Leadership is demonstrated by speaking truth to power. Strategic alignment with broad sector goals risks legitimacy (e.g. scope creep).
Missed Opportunities [Identity]	<ul style="list-style-type: none"> • If the organization does not engage in partnerships to address unmet social needs, it risks being uncompetitive with new payment and care delivery models. 	<ul style="list-style-type: none"> • If the organization does not engage in partnerships to address unmet social needs, it risks missing opportunities to weigh in on, conversations about priority populations and services.
Solving the Wrong Problem [Perception]	<ul style="list-style-type: none"> • Closed loop referrals do not address lack of service capacity or workforce that are not equipped to work across sector lines. • Cognitive dissonance from misalignment of problems and solutions undermines buy-in with stakeholders. 	
Exacerbating resource constraints [Perception]	<ul style="list-style-type: none"> • Primary resource constraint is availability of workforce. • Partnerships exacerbate constraints when they burn out staff or harm morale. 	<ul style="list-style-type: none"> • Primary resource constraint is funding for service capacity. • Partnerships exacerbate constraints when they add new clients or activities without additional funding.
Cost of Collaborating [Task Structure]	<ul style="list-style-type: none"> • Partnership is easier when an organization with power (such as a CCO) clearly acts as a convener. This reduces the burden of connecting with potential partners. The benefit of a convener is lost when multiple organizations compete for this role in a community. • Organizations with local focus perceive responsibility to behave collaboratively within the region. Organizations with multi-region focus perceive local collaboration to sometimes conflict with priorities at other levels (regional, state). 	
Signals of Trustworthiness [Task Structure]	<ul style="list-style-type: none"> • Partners demonstrate accountability by reporting results, meeting performance measures and upholding commitments. 	<ul style="list-style-type: none"> • Partners demonstrate accountability by being accessible, participating in group processes and taking time for relationship building.

Aim Three: Risks and Decision Making in Multi-Sector Partnerships

Aim Three of this research explored how perceived risks shape stakeholder negotiations and act as incentives or disincentives for organizations to strategically align their efforts in multi-sector health partnerships. As was discussed in Chapter Two, risk perceptions have implications for multi-sector collaboration because perceived risks do not need to materialize in order to influence individuals' behaviors; rather, individuals take actions to proactively avoid or manage the potential risks that they perceive (Beck, 1992). An organizational leader may opt to forego a collaborative activity altogether if the perceived risks for their organization are too high, even if doing so means that the community as a whole is worse off (for example, because of more fragmented service delivery or less efficient use of the community's resources).

The Appropriateness Framework (2004) suggests that individuals' behaviors in collective action dilemmas are driven by "decision rules" – heuristics that frame the range of acceptable actions according to an individual's identity, their perception of a situation, and the structure of the task to be completed (i.e. "what does a person like me do in a situation like this?"). To the extent that individuals perceive risk in collaboration, their potential responses to perceived risk are bounded by their decision rules. This research suggested that as HSO and SSO leaders weighed the risks and merits of multi-sector partnerships such as the AHC project through two types of decision rules: 1) who makes decisions about cross-sector collaboration within HSOs and SSOs; and 2) what condition(s) must be met in order to enter into a collaboration. These rules regarding decision makers and collaboration criteria have implications for how HSOs and SSOs

negotiate with one another in multi-sector partnerships. These are further discussed below.

Decision Makers and Authority

While decision making authority varied across organizations, it was clear from interviews that decision making about collaboration at HSOs and SSOs alike was a complex process involving many stakeholders. HSO leaders reported that these decisions were made by internal councils and committees, interdisciplinary teams, and leadership teams, with particular weight given to the perspectives of data analytics and quality improvement staff. In SSOs, boards, committees and senior managers were described as the primary decision makers about collaborations.

In contrast to HSOs, there was less emphasis in SSOs on data and analytic staff as decision makers or advisors in the process. More often, senior (but not executive) SSO managers were described as those whose perspectives carried the most weight. HSO and SSO leaders alike described relying on input from advisory councils of patients or clients when deciding to pursue a new partnership, as well as looking to these groups for feedback over time in order to know whether an initiative was going well. Across HSOs and SSOs, there was also a mix of decision making processes – some relied heavily on formal rules or procedures, internal proposals and assessment criteria, while others relied more on the perspectives and expertise of people in the organization.

This reliance by HSO and SSO leaders on decision making processes tailored to their specific organizational contexts, and the strong emphasis both groups placed on inclusive decision making that involved stakeholders within their organizations, is

consistent with the other findings from this research that securing buy-in from stakeholders was an important element of how HSO and SSO leaders mitigated the perceived risks of partnerships. In HSOs, where leaders perceived risk from staff burnout or turnover, there was stronger emphasis on engaging staff in decision making about new partnership opportunities. In SSOs, where leaders perceived risk related to securing and sustaining revenue, they often looked to and emphasized obtaining buy-in from others who shared fundraising responsibilities or were themselves funders of the SSO's work. In addition to underscoring that these behaviors are related to leaders' perceptions about resource dependence and constraints, these findings also echo stakeholder theory discussed in Chapter Two, that suggests organizations act to create value for the groups they perceive to be their core constituencies (Freeman, 1984; Mitchell, et al., 2015).

While obtaining buy-in for new partnerships from specific stakeholders was important for HSO and SSO leaders alike, this was related to another finding from this research: leaders expressed not knowing how to identify the appropriate individuals within their potential partner organizations with whom they should aim to develop relationships. This lack of clarity increased the perceived risk that partners may act in ways that were unpredictable or detrimental. As the literature on collective action dilemmas states, uncertainty about the behavior of others within a partnership increased HSO and SSO leaders' perceived risks of collaboration (Olson, 1965; Kollock, 1998; Ostrom, 2015; Feiock, 2013).

The finding that some HSO and SSO leaders expressed concern about holding one another accountable in collaboration because they lacked the ability to connect directly

with decision makers in their partner organizations was also consistent with theories of collective action dilemmas, suggesting that partnerships are less stable when they lack penalties or clear mechanisms for recourse if organizations defect from their commitments in a collaboration (Ostrom, 2015). This research suggests it is not just the presence of an accountability mechanism within partnerships, but also external clarity about who within an organization holds power to enforce accountability, that is important for reducing leaders' uncertainty about their partners' trustworthiness, motives and behaviors.

Criteria for Collaborative Action

HSO and SSO leaders alike expressed that it was highly likely their organizations would continue to pursue multi-sector partnerships, assuming that certain criteria were met. HSO and SSO leaders' thinking about the conditions that must be met for their organizations to engage in multi-sector collaborations are synthesized in Table 5.2 below and reflect simplified "heuristics" or decision rules that emerged during the analysis.

Table 5.2: Organizational Leaders' Criteria for Collaborative Action

Considerations [and Domain]	Partnerships should:
What kind of people are we? [Identity]	<ul style="list-style-type: none"> • Be a priority for our stakeholders (including staff) • Be aligned with our mission, priority population or issues • Be consistent with our obligations to our beneficiaries • Not give the appearance of a conflict of interest or appear as "chasing funding"
What kind of situation is this? [Perception]	<ul style="list-style-type: none"> • Mitigate our resource constraints • Explicitly recognize our contribution to jointly produced efforts or outcomes • Be something we can confidently do well
What are my options and constraints? [Task Structure]	<ul style="list-style-type: none"> • Not undermine our other projects or initiatives • Allow us to see and directly interact with our partners' decision makers • Not conflict with other rules/requirements we have to follow

These criteria for whether a multi-sector partnership should be pursued can be further synthesized as 1) whether the potential partnership reinforces and enhances organizational identity; 2) whether it mitigates or exacerbates an organization's resource constraints; and 3) whether and how it creates new sources of uncertainty or ambiguity for the organization. These findings are largely consistent with, and echo the literature on, social construction (Schneider and Ingram, 1993), resource dependence (Pfeffer and Salancik, 1978), transaction costs (Williamson, 1973) and organizational behavior in collective action dilemmas (Kollock, 1998; Weber, Kopelman and Messick, 2004) that was presented in Chapter Two.

This research confirmed that the social construction (Schneider and Ingram, 1993) of HSOs' and SSOs' client groups and beneficiaries can create clear and often rigid professional boundaries for their leaders, shaping their perceived risks of collaboration with other sectors. The organization's identity – expressed through its stakeholders, mission, professional obligations and strategic priorities – was defined by the groups it was serving, which in turn had typically been externally constructed through policy or funding streams (Sabatier & Wieble, 2014). Though these HSO and SSO organizations served the same geographic communities and, in many cases, the same clients, the range of collaboration activities that HSO and SSO leaders deemed acceptable was clearly limited to activities that did not require their organizations to flex or change the categorical definitions of their service populations or priority issues. Partner organizations that were perceived to define their populations or issues similarly were described as easier to collaborate with.

This finding echoes research on collective action dilemmas suggesting that individuals have higher expectations for reciprocity from, and more strongly consider the effect of their actions on, others who they perceive to be “within group” members (Lax and Sebenius, 1987; Kollock, 1998). The literature suggests such boundaries can be strategically reframed to create new shared identity among organizations in ways that foster trust and cooperation (Exworthy, 1998); the possible implications for cross-sector projects such as AHC are discussed in the recommendations presented at the end of this chapter.

The findings of this research are also consistent with resource dependence and transaction cost literature presented in Chapter Two, suggesting that control of community health promotion resources (Pfeffer and Salancik, 1978) and health and social service infrastructure (Williamson, 2002) become points of conflict as well as opportunities for collaborative action. HSO and SSO leaders are increasingly presented with research that illuminates how their respective programs and services affect one another’s outcomes (Bradey and Taylor, 2013; Bradley, et al., 2016) and both sectors face increasing pressure to demonstrate quantifiable improvement in their outcomes (Benjamin, 2008; Hargunani, 2017). These theories suggest it would be expected that HSO and SSO leaders would react by seeking to exert greater influence or control over one another’s activities through mechanisms such as community health improvement plans or leadership of community alliances (Pfeffer and Salancik, 1978; Oliver, 1990). Similarly, these theories suggest that as HSO and SSO sectors become more integrated and dependent on one another to collaborate, the potential for exploitation or coercion

among organizations will also increase (Williamson, 1973; Kollock, 1998). The patterns observed in the AHC communities may reflect early indications of this; across regions, as participants described more frequent or numerous cross-sector meetings, participants' references to power struggles over these groups' agendas also increased.

Finally, this research is consistent with prior research on the effects of environmental uncertainty on decision making in collective action dilemmas (Howard, 1989; Kollock, 1998; Adam, et al., 2002). The literature notes that even when individuals face similar levels or types of environmental uncertainty, risk preferences can vary among individuals based on different rules and norms of behavior that are socially constructed (Sandman, 1989; Beck, 1992). This research suggested that HSO and SSO leaders possessed different risk preferences with respect to the uncertainties of multi-sector collaboration. While HSO leaders described higher tolerance for experimentation with new models or approaches to their daily activities, they were relatively risk averse to anything that was perceived unlikely to result in measurable improvements in health outcomes (including activities that did not generate data).

Conversely, SSO leaders expressed a higher tolerance for uncertain client outcomes (or activities that could not be easily measured), specifically because they were less tolerant of activities that restricted clients' options or choices. This may, in turn, be related to differences in the funding models of the HSO and SSO sectors, as prior research has shown that organizations that are highly reliant on public support (as SSOs are) have less risk tolerance for, and face the risk of greater public backlash when they

adopt, innovations in their service delivery models (Chen and Bozeman, 2012; D'este, et al., 2012; Torugsa and Arundel, 2017).

In summary, this research revealed differences in how HSO and SSO leaders' risk perceptions manifested through their decision making about multi-sector partnerships. HSO and SSO leaders looked to different groups of stakeholders or authorities to build consensus within their organizations for new collaborations, and also sought to understand the decision making processes of their partner organizations. When leaders were not able to directly relate to other leaders in their potential partner organizations, they expressed concerns about being exploited or being unable to hold partners accountable, leading them to look for partner organizations whose leaders were more visible or accessible. In addition to revealing differences in HSO and SSO decision making roles, this research found that HSO and SSO leaders' heuristics or decision rules regarding the appropriateness of multi-sector partnerships varied by their socially constructed organizational identities, their organizational resource dependencies, and their tolerance for certain types of uncertainty within their operating environments.

Aim Four: Recommendations for Policy and Systems Change

Aim Four of this research was addressed through a discussion of the implications of HSO and SSO leaders' risk perceptions for policy or systems change, and the identification of opportunities to better incentivize organizational strategic alignment within multi-sector health partnerships. This section presents the findings on this aim in the form of recommendations for three audiences: 1) conveners of screening and referral projects such as AHC, 2) regional health alliances or initiatives, and 3) policymakers and

fundings at the regional and local level. These recommendations address opportunities to mitigate health and social service leaders' perceived collaboration risks that were identified through this research. Each recommendation includes a reference to the specific perceived risk from Table 5.1 or the criteria for collaboration from Table 5.2 that it is intended to address.

Recommendations for Screening and Referral Initiatives

This research identifies the following opportunities for leaders of screening and referral projects such as AHC to foster strategic alignment between health and social services organizations.

Reframe Purpose and Goals. Closed-loop referrals are just one of many possible benefits of a screening and referral network, and this research suggested that closed-loop referrals may not be a particularly effective value proposition for HSO or SSO leaders to collaborate, due to perceived limitations of referrals for cultivating system change (see Table 5.1, "Solving the Wrong Problem"). Alternative value propositions that projects such as AHC may use in their communications may be the potential value of local social needs data for highly targeted community needs assessment, regional planning and resource allocation. The potential for projects such as AHC to help "map the system of care" in a rural community may also be motivating to HSO and SSO leaders as a way to become more aware of one another, raise awareness and understanding of their own programs and services, and reduce potential duplication of their efforts or competition with other organizations for resources.

Engage Screening and Referral Organizations as Early as Possible. SSO

leaders feared being “left behind” in health sector conversations about social determinants of health (see Table 5.1, “Missed Opportunities”), while also fearing that collaboration would require new work without funding or reimbursement (see Table 5.1, “Exacerbating Resource Constraints”). SSO leaders and staff can participate in projects such as AHC in an advisory capacity in order to offer their expertise to HSOs within these projects even if their organizations are not directly engaged in patient screening or navigation activities. For SSOs, this can mitigate concerns that project leaders and/or participating HSOs are generating referrals without engaging or understanding the organizations to whom they are referring their clients (see Table 5.2, “What kind of situation is this?”).

Whenever possible, the design of projects such as AHC should include funding to compensate organizations for the time they contribute to participating as advisors. When this is not possible, SSO leaders may still justify their participation in projects such as AHC as advocating their priorities and sharing best practices for referrals with their HSO partners. SSO and HSO leaders and staff may be encouraged or invited to give presentations on their programs and services or develop fact sheets or issue briefs that can help local partners understand preferred ways to refer clients for services as well as identify opportunities to support and strengthen one another’s service delivery capacity.

Emphasize Accountability for Project Outputs and Relationship

Development. The reliance of projects such as AHC on output measures such as counts of individuals screened or numbers of services provided reflects a health sector

orientation toward organizational accountability and performance management, and is well suited to bolster health service organizations' credibility when they participate in projects such as AHC. However, this orientation may not adequately address social service organization norms regarding trust and accountability through relationship development (see Table 5.2, "Signals of Trustworthiness"), or fears of coercion or scope creep when working with health service organizations (see Table 5.1, "Threats to Credibility"). These differences may become a more substantial barrier to collaboration as projects such as AHC seek to increase SSO engagement over time.

To balance health and social sector norms regarding accountability within multi-sector projects, screening and referral projects can be designed with goals related to both client-level outputs and outcomes, as well as measures of inter-organizational relationship development such as degree and consistency of leadership engagement in group planning, or participant awareness or understanding of their partner organizations' services, programs and approaches. Project conveners may leverage contracts and memoranda of understanding as tools to encourage participants to explicitly identify who is responsible for inter-organizational relationship development and how this information will be conveyed to external partners; this information can be shared with others in the group to improve understanding about how participants can directly hold one another accountable.

Minimize Training and Data Collection Burdens. The burden of new training and data collection activities in projects such as AHC was a particular concern for HSO leaders, while SSO leaders shared concerns that HSO staff may not be adequately trained

or equipped for new workflows (see Table 5.2, “Exacerbating Resource Constraints).”

New workflows and tools for social needs screening and referral projects should be designed with consideration for staff turnover and the reality that many HSOs engaged in screening and referral projects such as AHC will have to repeat trainings with new staff on an ongoing basis in order to maintain these processes and workflows over time.

Trainings can be designed that are intended to be provided on a rolling basis. Data collection instruments and data entry portals can be designed to minimize the necessity for specialized training or knowledge by staff users. HSOs can also be encouraged to proactively develop staff transition plans related to projects such as AHC as well as broader community engagement efforts.

Recommendations for Regional Governance of Population Health Efforts

This research points to considerations for organizations involved in regional population health efforts such as community health needs assessments, regional health improvement plans or collective impact efforts. The nature of such efforts is highly variable across regions and states depending on the policy context and the specific mix of service provider organizations in the region. The following are recommendations for individuals in rural areas of Oregon who convene or participate in governance activities for these types of multi-sector groups, although these recommendations may be transferable to other regions.

Clearly Signal the Role of Coordinated Care Organizations as Regional Conveners. Coordinated Care Organizations are well positioned to convene regional multi-sector meetings due to their requirement to engage Community Advisory Councils

(CACs), their high regional visibility (particularly in rural areas), and their ability to incentivize organizations' participation through the promise of access to funding (Oregon Health Policy Board, 2018). Yet this research revealed that, in some AHC regions, CCOs had not clearly signaled to organizations that they intended to operate as regional conveners of cross-sector collaboration or given clear direction to organizations regarding how to engage in CCO meetings (see Table 5.2, "Cost of Collaborating"), leading to confusion about who, if anyone, should occupy this role.

Whenever possible, CCO staff and leadership should aim to clearly position themselves as regional conveners (not simply funders) of multi-sector collaboration, and their community meetings as settings where organizations are encouraged to develop cross-sector connections, to avoid confusion about roles or creation of potentially duplicative meeting structures. While CCOs cannot prevent other organizations from developing parallel meetings or governance structures, they can communicate the importance of community partners having a shared understanding about where and how to connect with one another. Local and state policymakers can bolster the CCO role as convener by participating, or assigning staff representatives to participate on their behalf, in CCOs' community meetings.

Leverage Regional Meetings to Help Organizations Identify and Connect with Partners. This research revealed that low visibility of potential cross-sector partners and lack of understanding of service delivery models concerned both HSO and SSO leaders, but they often did not perceive existing strategies such as CCO initiatives or the AHC project to be addressing these problems (see Table 5.2, "Solving the Wrong

Problem” and “Cost of Collaborating”). Conveners of regional population health meetings or groups should explicitly encourage attendance from non-health sector organizations such as SSOs to avoid the perception that these meetings are exclusive spaces intended primarily for HSOs. Disseminating information about community meetings or population health initiatives through non-health sector channels, such as local nonprofit consortia or professional listservs for agencies providing specific services, may be important to ensure visibility and signal intention to engage non-HSO participants (see Table 5.2, “Signals of Trustworthiness”).

Where possible, time should be dedicated within existing regional meetings for organizations to share information with one another about their programs, services and strategic priorities, as well as contextual factors such as their regulatory and funding requirements and the philosophical foundations of their service delivery models. Conveners can signal that increased interprofessional awareness and understanding of one another’s service models is an explicit goal of community meetings (in addition to specific project outputs or activities) to legitimize the time organizational leaders spend on these activities.

Monitor Group Dynamics and Mitigate Power Differences. This research revealed that organizational leaders were highly attuned to how potential partnerships could enhance or undermine their interests or their reputation within the community (see Table 5.2, “Threats to Credibility”). Since organizations do not enter into partnerships with equal levels of power, market share or resources, differences in these organizational

characteristics can be sources of distrust or misunderstanding about potential partner organizations' motives or trustworthiness (see Table 5.2, "Signals of Trustworthiness").

CCOs and other conveners of regional health initiatives should take steps to proactively solicit ongoing feedback about the inclusiveness of cross-sector meetings, facilitation, agenda setting and decision making processes, in order to minimize the likelihood that organizations will opt to develop their own alternative community meetings over which they have greater control. While no meeting structure will address all needs or concerns, rapid cycle evaluation of these efforts may identify challenges with group dynamics or opportunities for improvements in process that are otherwise invisible to conveners of these groups. Conveners should proactively monitor and aim to mitigate perceived power differences between large and small organizations, physical health organizations and those providing other services, and between organizations serving highly socially stigmatized populations and those serving broader or more loosely defined client groups.

Acknowledge that Regional Health Priorities De-emphasize Other Issues This research revealed that organizational leaders perceived risk in the adoption of shared cross-sector priorities because it potentially undermined the efforts of organizations whose populations or issues were not chosen as priorities by the group. While it may not be possible (or even desirable) to prevent this dynamic, it should be explicitly acknowledged (see Table 5.2, "Threats to Credibility" and "Missed Opportunities"). Conveners should aim to balance the perspectives of health and social sector organizations in decision making about regional goals to address social determinants of

health, in order to address concerns about representation of social service organizations or sharing of credit for jointly produced outcomes within regional health planning (see Table 5.2, “Missed Opportunities”).

Conveners may also need to explicitly acknowledge organizations whose issues do not rise to the top of the collective agenda, in order that these organizations are not alienated by regional initiatives. Groups can take steps to identify when the adoption of certain priorities may create feelings of competition, or shift attention or resources away from, other organizations’ work (for example, whether adopting a regional goal related to children’s health may indirectly threaten the region’s organizations serving seniors). Groups can proactively consider whether and how to mitigate these dynamics when they arise. While it may be impossible to avoid the presence of such externalities across organizations, it may be possible to mitigate the effect of these dynamics on inter-organizational trust and cooperation (see Table 5.2, “What are my options and constraints?”).

Recommendations for Regional and Local Policymakers and Funders

This research points to the following recommendations for policy makers and individuals in decision making roles overseeing the distribution of resources for local and regional population health efforts (including local government agencies and private foundations):

Signal that cross-sector collaboration is a priority at the regional and local levels. While health and social sector leaders at the national, and in some cases, state levels have called for greater attention to addressing social determinants of health through

multi-sector collaboration (Weil, 2016; Oregon Health Policy Board, 2018), this research revealed that participants perceived lack of engagement in these issues from regional and local policymakers (see Table 5.1, “Cost of Collaborating”). This research also revealed HSO and SSO leaders were highly attuned to the reputational effects of engaging in multi-sector partnerships, and valued projects that could enhance their reputation as leaders in the field on issues that their funders cared about (see Table 5.2, “What Kind of People Are We?”). Local policymakers and leaders of foundations and public agencies that fund services at the regional or local level can signal the importance of organizations continuing to engage in multi-sector partnerships and underscore this support by participating in, or having senior staff participate in, regional multi-sector meetings and collaboratives.

Provide financial support for activities that support multi-sector engagement. HSO and SSO leaders perceived financial barriers to SSOs collaboration with HSOs, including misaligned service populations (see Table 5.1, “Threats to Credibility”), lack of dedicated funding to participate in health sector initiatives (see Table 5.1, “Exacerbating Resource Constraints”), or lack of capacity to provide services to address unmet social needs that were identified by health care partners (see Table 5.1, “Solving the Wrong Problem”).

Policymakers and funders who oversee restricted funding streams for the provision of specific services or for specific populations in their communities can incentivize multi-sector approaches in those efforts by aligning definitions of categorical eligibility for services or program quality across funding streams (see Table 5.2, “What

kind of people are we?”). Examples include adopting the same or similar geographic boundaries, age bands, or income guidelines in defining target populations or by aligning documentation requirements to establish clients’ eligibility through screening tools or intake forms. Public and private funders can also design programmatic funding streams that explicitly support and incentivize cross-sector relationship development at the leadership level by, for example, allowing organizations to account for participation in regional meetings or alliances as programmatic rather than administrative costs (see Table 5.2, “What kind of situation is this?”). In Oregon (as well as a number of other states operating under federal Medicaid demonstration waivers), policy initiatives promoting the adoption of new Medicaid payment models present new opportunities to support these kinds of cross-sector planning or service coordination activities as “health related services” (Kushner and McConnell, 2019).

Align Regional Workforce Strategies across Health and Social Services. As HSOs move toward new models for community-based care employing community health workers, peer supports or navigators, their workforce needs will increasingly overlap with SSOs. This could present a collaborative opportunity or a competitive threat for both sectors depending on how regional workforce strategies respond to these pressures (see Table 5.1, “Exacerbating Resource Constraints”). Policymakers and funders can support workforce development strategies in the region that aim to minimize competitive pressures for overlapping workforces by striving for wage parity across health and social sectors (see Table 5.2, “What kind of situation is this?”). The potential overlap in HSO and SSO workforce also presents an opportunity to cultivate “boundary spanning”

professionals whose training equips them to navigate both health and social sector organizational cultures and advocate models of service that integrate best practices of both health and social sectors (Watson and Foster-Fishman, 2013) (see Table 5.2, “What kind of people are we?”). Funders can enhance cross-sector learning at the local level through support of activities such as interprofessional trainings and learning collaboratives specifically designed to increase awareness and understanding of different service delivery models across health and social services. There is already precedent for this type of education-based approach to cross-sector learning through programs that have been developed to train care professionals to work in interprofessional teams (Bedoya, et al., 2018).

A summary of the implications of this research and recommendations for leaders of screening and referral initiatives, for governance of regional population health efforts, and for regional and local policymakers and funders is presented in Table 5.3 below.

Conclusion

The collaborative risk perceptions of HSO and SSO leaders that were revealed by this research are consistent with prior conceptual and empirical literature describing dynamics within collective action dilemmas. These findings confirm that health and human service organizations adapt to the operating requirements and social norms of their respective fields, and that the changes required to strategically align organizations within a multi-sector partnership can create tensions with these sector rules and norms to which organizations have adapted.

Table 5.3: Recommendations for Policy and Systems Change

For Leadership of Screening and Referral Initiatives	<ul style="list-style-type: none">• Reframe the purpose, goals or intended outcomes of these efforts to reflect HSO and SSO value propositions.• Engage both screening and referral organizations in project discussions as early as possible.• Minimize the training and data collection burden for client screening and navigation activities.• Emphasize organizational accountability for both project outputs and relationship development.
For Governance of Regional Population Health Initiatives	<ul style="list-style-type: none">• Coordinated Care Organizations should fully embody their role as regional conveners.• Intentionally use regional meetings to help organizations identify and connect with potential cross-sector partners.• Proactively monitor group dynamics and take steps to mitigate power differences.• Acknowledge that the adoption of regional health goals or priorities necessarily de-emphasizes some organizations' priority issues and populations.
For Regional and Local Policymakers and Funders	<ul style="list-style-type: none">• Signal that cross-sector collaboration is a priority at the regional and level.• Provide financial support for activities that support multi-sector engagement.• Support alignment of regional workforce development strategies across health and social services.

Organizational leaders also perceive risk in trusting the motives or actions of potential partners in the community, and in adopting shared regional goals for collective action, which appeared to vary across regions according to specific organizational histories and strength of connections to the local community. These findings also indicate that entities that act as regional conveners, such as Accountable Health Communities or Coordinated Care Organizations, are a factor in how organizations perceive risk in multi-sector collaboration within their communities.

The literature summarized in Chapter Two established cross-sector collaboration as a “wicked problem” that persists over time, and this research confirmed that inter-organizational dynamics within projects such as AHC can resemble a collective action dilemma where organizations face a complex array of sometimes conflicting incentives

and vulnerabilities. Despite the complexity of these dynamics and the highly variable contexts in which these collaborative efforts occur, this research pointed to certain shifts that may be within reach for organizational leaders or policymakers; this research presented a series of recommendations that cannot resolve, but may work to mitigate, the perceived risks of cross-sector partnerships.

Chapter Six – Limitations, Future Research Directions, and Conclusion

Overview

While this study was conducted with attention to methodological rigor and the use of best practices for case study research, the study design includes certain weaknesses that limit the generalizability of the findings and may have introduced bias into the data collection and analysis. These limitations are discussed in this chapter, with suggestions of ways the research design could have been improved or enhanced. New questions and opportunities to extend these findings through additional research are identified, and recommendations for future research are described in detail below.

Limitations of this Research

The limitations of this research, including threats to validity and the potential for selection bias, as well as inherent limitations of the observational study design, are discussed below.

Threats to Validity

Case study design principles include the importance of building trustworthiness and rapport with participants over time (Maxwell, 2013; Yin, 2003). For this research study, the development of trust and rapport with participants over time had to be balanced against the time burden of participation, in order to ensure that a sufficient number of participants responded to the invitation. Participants were given the option of completing an interview in person, by phone or video conference to maximize convenience for them. All 23 participants opted to be interviewed by phone, which

limited opportunities for the researcher to build rapport through face-to-face contact or observe the participants in the context of their physical work environment. While video conferencing could have partially mitigated this issue, it required that participants conduct the interview near a computer with video capabilities, and this option was frequently declined by participants in order to complete the interview in a more private or convenient setting than their offices (such as a home or vehicle). Despite the limited contact and lack of history between participants and the researcher, participants were generally forthcoming and willing to answer questions during interviews. However, the research would have benefited from a longer study period and site visits to participants' organizations, even if these visits occurred separately from participant interviews. Conversely, this step may have also increased the burden of participation in the study and adversely affected participant recruitment.

While this research involved the development of a case study database, triangulation of multiple sources of data and construction of a "chain of evidence" to support the validity of findings (Yin, 2003), data collection and analysis for this study were conducted by a single researcher. Analysis of interview data relied primarily on thematic codes developed from the study's theoretical framework (Maxwell, 2013). The researcher supplemented these *a priori* thematic codes with a limited number of emergent codes. It is possible that a different researcher or team of researchers may have developed different codes or applied the same set of codes differently to these data; in doing so, another researcher may have emphasized different themes or findings. This study would have benefited from the inclusion of a second researcher during the coding

and analysis stage to allow for comparison and reconciliation of any differences in use of codes or interpretation of data. However, this was not feasible since this study was conducted as dissertation research within an academic program where a single perspective is an expectation of the academic experience.

This is not meant to imply that an objective truth existed within the data that could be found through the correct use of codes, but rather to acknowledge that the researcher's personal judgment was an integral aspect of data analysis (Maxwell, 2013). Related to this, the study design would have benefited from respondent validation or "member checking" of the researcher's interpretation of key themes by presenting them to the study's participants for additional feedback during the analysis stage (Maxwell, 2013). Resources did not allow for including this additional step, so the researcher engaged in more limited validation through discussion of preliminary themes with ORPRN staff who had first-hand knowledge of the AHC project and its participants.

Selection Bias and Small Samples

This study relied on maximum variation sampling and a fairly small study population (described in detail in Chapter Three). Selection criteria for social service organization (SSO) participants prioritized the five social services emphasized in the AHC project (i.e., food, transportation, housing, utilities and personal safety/violence prevention). Selection criteria for health service organization (HSO) participants prioritized diversity of service types among the organizations participating in AHC as screeners (i.e., primary care, dental care, patient navigation and care coordination, public health, etc.). While this yielded a final study population of organizational leaders

representing a broad range of service types, this approach did not allow for drawing more detailed conclusions about the specific risks of multi-sector partnerships perceived by any single type (such as dental or housing organization leaders specifically). Organizations within these sub-sectors operate within different regulatory and funding environments, and perceived risks of collaboration likely vary among these types of organizations.

As well, because the sampling frame for this study resulted in a heterogeneous mix of organization types and sizes among the four AHC regions (for example, a public health agency and Area Agency on Aging in one region and a Housing Authority and primary care clinic in another region), it is possible that some of the variation in attitudes and partnership activities observed across the four AHC regions can be attributed to differences in the types of organizations recruited within each region, rather than differences among the regions as a whole. Future research could employ a sampling strategy that held constant the type of organizations recruited across regions (for example, recruiting a housing agency within each region) and comparing among them, in order to further explore regional variations while also drawing more specific conclusions about perceived risks related to particular types of organizations.

These communities also had prior or co-occurring projects beyond the AHC project that in some cases had similar goals or strategies (such as developing screening and referral networks to address social determinants of health). Participants' views of the AHC project were interwoven with their experience of these other collaborations, as the Appropriateness Framework (Weber, Kopelman and Messick, 2004) suggests. More detailed data collection about other co-occurring SDoH initiatives would be useful to

provide better context for how parallel initiatives may interact or influence one another over time.

This limitation also points to the difficulty of drawing generalizable conclusions about cross-sector collaboration from any study of a community intervention such as AHC, given that even when the same project is consistently implemented across multiple communities, the specific mix of organizations involved or presence of parallel initiatives will vary, and could yield differences in project outcomes that have little to do with the strategy or fidelity of the project's implementation in a given community (Kadushin, et al., 2005). The histories of collaboration in a community when it embarks on a project such as AHC (i.e. its members' baseline perceptions) are an important component of the community's response to a new collaborative intervention (Kadushin, et al., 2005). In general, research and evaluation conducted on multi-sector health partnerships would benefit from acknowledging and accounting for these baseline differences through study design.

Observational Design

Finally, it is important to note the temporality of the findings of this research. Data were collected at a single point in time, early in the implementation of AHC in Oregon. It is very likely that participants' responses to these interview and survey questions would evolve over the course of AHC implementation. In particular, the early stage at which data were collected meant that nearly all SSO leaders were not yet familiar with the AHC project. SSO leaders' responses to questions about collaboration, including

more specific questions about screening and referral networks, were highly generalized rather than tailored to the specific design or implementation of the AHC project.

In contrast, HSO leaders had interacted with ORPRN AHC project staff, received substantial information about the project, and begun implementing screenings. Their responses to interview questions sometimes delved into very specific details of the AHC project's data management system or screening protocol. It is too early in AHC implementation to say whether these differences in HSO and SSO knowledge about the project will persist over time, or to draw any meaningful conclusions about how these differences might relate to the specific approach used by the Oregon AHC project. This is not a weakness of this research design so much as an opportunity for further follow-up; as was described above, understanding the “baseline” perceptions of participants may be an important aspect of following the evolution of a cross-sector intervention over time.

In summary, there were specific limitations in this research approach, including the short study period, limited resources, reliance on a single researcher, heterogeneity of case communities, timing of data collection and presence of co-occurring community initiatives with similar overarching goals to the AHC project. These weaknesses were mitigated where possible, but future research could improve the rigor of these findings through specific steps such as a longer study period to build rapport with participants over time or respondent validation of findings.

Recommendations for Future Research

There are opportunities to expand on the findings from this research through additional studies. Some specific opportunities and recommendations for future research include:

Conduct follow-up research of the AHC communities later in project implementation. Follow-up research conducted within one to two years (late 2020 or 2021) would allow for an examination of how participants' risk perceptions may evolve over time. Follow-up research conducted at the conclusion of the AHC project (2022) could explore to what extent participants' concerns or worries manifested as the project unfolded, as well as the identification of any strategies that participants used to mitigate or avoid the risks they perceived at baseline, which could yield valuable lessons for other communities. Finally, a follow-up study in these four communities after the conclusion of the AHC project in 2022 may yield insights regarding the possible "path dependency" of communities that embark on similar collaborative projects but with different baseline histories of successful or strained cross-sector collaborations. This could be a valuable and potentially generalizable insight for policymakers regarding multi-sector partnerships.

Investigate how differences in population definitions and eligibility criteria across health and human services policies impede or support the coordination of care at the local level. Participants for this research described how misaligned definitions or rules in federal policies such as the Older Americans Act, Medicaid, the Violence Against Women Act or Supplemental Nutrition Program for Women, Infants

and Children (WIC) created barriers to cross-sector coordination of services. A deeper exploration of how federal and state policies complement or conflict with each other at the point of service provision is an area where further research could yield helpful insights and recommendations to better align health and human services policies. For example, how do eligibility criteria or rules across Medicaid, Meals on Wheels, and Dial-a-Ride programs facilitate or impede the coordination of services for a low-income elderly individual who is discharged from a rural hospital with a need for ongoing social support? Case study research could prove especially illuminating and useful in this area.

Explore how successful multi-sector collaboration may vary in urban, suburban and rural areas. Despite the four AHC regions all being described in this research as “rural” areas, there are substantial differences in the four communities’ population densities and geographic characteristics, and the diversity and spatial distribution of organizations serving the regions. In some regions, organizations and their client populations were described as residing within relatively concentrated and accessible areas, whereas other communities were described as being distributed across a wide area with natural and built physical challenges to connection (such as mountain ranges, or lack of broadband internet infrastructure or cellular phone networks). In some regions, there were multiple organizations providing a particular type of resources and, in others, only a single organization that did so. Future research could explore the ways that these structural and social differences in communities may require different approaches to interventions such as screening and referral networks. It is likely that tools and techniques that work well for aligning services in very small communities may work

poorly or not at all in more suburban areas with greater population density and organizational diversity. How these differences may affect the success of projects such as AHC is not well understood.

Explore how different constructions of group identity and membership may relate to organizational leaders' willingness to collaborate in multi-sector partnerships. Organizations can be grouped multiple ways when conceptualizing partnership research, including as members of a geographic community, as part of a sector or industry, as members of a provider network, by service type, by size, etc. Organizations possess many of these identities. While the purpose of this research was not to systematically explore and compare these groupings, this research suggested that organizational leaders may identify more strongly with some of these categorical distinctions than others (i.e., geographic identity appeared to be a stronger factor than sector identity when organizational leaders described responsibilities to behave cooperatively toward others). If true, this could have implications for group dynamics within multi-sector partnerships or other collaborative efforts such as community health improvement plans, because people are more naturally collaborative toward others they perceive to be members of a shared group than they are toward those who they perceive to be outside of the group (Kollock, 1998). There may be opportunities to strategically frame group boundaries and group identity in projects such as AHC in ways that enhance collaborative behavior.

In summary, this study points to opportunities for future research that would complement or extend its findings. These include additional follow-up study in the AHC

communities to monitor changes over time; further case study research of how federal health and human service policies complement or conflict with each other at the point of service delivery; further exploration of how urban, rural and suburban areas may respond differently to collaborative interventions or need different types of support; and investigation of how different constructions of group identity and membership may be more or less potent incentives for organizational leaders to behave cooperatively with one another in a group.

Research Summary

In summary, the purpose of this research was to answer the question “How are the organizational risks of strategic alignment perceived by stakeholders within communities for health?” Chapter One provided context for this research question: how it emerged from current discussions and unresolved challenges in literature about multi-sector health partnerships, and its relevance for current health and human services policy debates.

Chapter Two provided an in-depth discussion of the historical context for multi-sector health partnerships and emerging “communities for health” and how the research question could be situated within a broad field of prior research on organizational behavior and collective action dilemmas. The question posed in this dissertation extended existing literature by directly linking current observed challenges in multi-sector health partnerships to organizational theory and collective action literature, drawing connections between theory and practice.

Chapter Three described in detail the analytic methods used to address the research question and aims, along with providing justification for the selection of

Oregon's Accountable Health Communities as a case study. Chapter Four presented a detailed description of the participants who were recruited and data that were collected and analyzed for this research. Findings included:

- a detailed case description of the Accountable Health Communities project and its four implementation regions in Oregon at the time of this research;
- key themes related to health and human service sector leaders' perceptions of risk in multi-sector health partnerships when the data were analyzed through the lens of the Appropriateness Framework (Weber, Kopelman and Messick, 2004); and
- the similarities and differences in these themes when participants were segmented by sector and by geographic region.

Chapter Five provided an overall synthesis of the findings from Chapter Four and a detailed discussion of the four research aims, including key takeaways regarding risk perceptions; the implications for design, governance and implementation of multi-sector health partnerships; and recommendations for policymakers and health and human service sector leaders. These conclusions from Chapter Five were followed by a discussion in Chapter Six of some of the inherent limitations of the research design and methods used, implications for interpreting the findings and conclusions of this research, and potential areas for future research.

Conclusion

In conclusion, this research found that when multi-sector partnerships such as AHC are examined through the lens of the Appropriateness Framework for understanding decision making in collective action dilemmas (Weber, Kopelman and Messick, 2004), health and human service leaders describe different constraints and resource dependencies and hold different views on whether and how multi-sector collaboration

advances their organizational interests. Health and human service organizations operate within different sociopolitical contexts and are highly adapted to specific service populations, issues and funding streams that are narrowly defined within various federal health and human services policy. Misalignment of these categorical distinctions at the federal level creates perceived risks in multi-sector collaboration at the point of service delivery due to potential noncompliance or risks of reputational harm.

Health and human service leaders described the purpose of projects such as AHC in terms of increasing connectedness of, and interprofessional knowledge among, the health and human services workforces rather than increasing the ability of their clients to access services. This research suggests the value of multi-sector collaboration through interventions such as AHC, regional health alliances or the advisory committees of Coordinated Care Organizations, may be in increasing organizations' visibility and helping organizational leaders identify partners and better advocate their interests within their community (particularly through community-level data). Achieving balance between this perceived value of collaborations and the perceived cost of new meetings or accountabilities appears to be a delicate process, easily destabilized when multiple collaborative efforts compete for the role of convener in the community.

Finally, this research revealed that groups of organizations that operate as collaboratives, alliances or "communities for health" possess complex social dynamics, with power exercised by organizations in subtle ways such as control over community meeting agendas and community health improvement plans. Researchers are increasingly identifying the ways that health and human services work is interconnected in its delivery

and its outcomes, revealing new opportunities for both sectors to influence one another or try to exercise control over shared resources. As policymakers and organizational leaders seek new ways to promote population health by aligning the design, financing and delivery of health and human services at the community level, this research suggests it may be important to monitor how power is exercised within multi-sector partnerships, recognizing that any effort that aligns organizations around shared health priorities will also direct attention away from some issues, and any effort to establish shared infrastructure for cross-sector coordination will also create new opportunities for these systems to be exploited.

References

- “About.” (n.d.). The BUILD Health Challenge. Retrieved May 22, 2018, from <http://buildhealthchallenge.org/about/>
- “About CNPP.” (n.d.). U.S. Dept. of Agriculture. Retrieved April 18, 2018, from <https://www.cnpp.usda.gov/about-cnpp>
- “About FNS.” (2017, March 24). U.S. Dept. of Agriculture. Retrieved April 18, 2018, from <https://www.fns.usda.gov/about-fns>
- “About the Elder Justice Initiative.” (n.d.). U.S. Dept. of Justice. Retrieved February 16, 2018, from <https://www.justice.gov/elderjustice/about-eji>
- “About the Military Health System.” (n.d.). U.S. Dept. of Defense. Retrieved February 16, 2018, from <http://health.mil/About-MHS>
- “Accountable Health Communities Model.” (2018, July 26). Centers for Medicare and Medicaid Services. Retrieved August 19, 2018, from <https://innovation.cms.gov/initiatives/ahcm/>
- “Accountable Health Communities Model Fact Sheet.” (2016, January 5). Centers for Medicare and Medicaid Services. Retrieved February 16, 2017, from <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-05.html>
- Adam, B., Beck, U., & Van Loon, J. (2000). *The Risk Society and Beyond: Critical Issues for Social Theory*. London, UK: Sage Publications.
- Adler, N. E., & Stead, W. W. (2015). Patients in Context - EHR Capture of Social and Behavioral Determinants of Health. *New England Journal of Medicine*, 372(8), 698–701.
- Adler, N. E., & Stewart, J. (2010). Health Disparities Across the Lifespan: Meaning, Methods, and Mechanisms. *Annals of The New York Academy of Sciences*, 1186(1), 5–23.
- Akerlof, G. A. (1982). Labor Contracts as Partial Gift Exchange. *The Quarterly Journal of Economics*, 97(4), 543–569.

- “Alignment of Clinical and Community Resources - Elements that Support Payment Reform for Population Health (Issue Brief).” (2017a). Payment Reform for Population Health Initiative. Washington, DC: AcademyHealth.
- Alley, D. E., Asomugha, C. N., Conway, P. H., & Sanghavi, D. M. (2016). Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid. *New England Journal of Medicine*, 374(1), 8–11.
- Allison, G., & Zelikow, P. (1999). *The Essence of Decision: Explaining the Cuban Missile Crisis* (2nd ed.). Glenview, IL: Addison-Wesley Educational Publishers Inc.
- Amarasingham, R., Xie, B., Karam, A., Nguyen, N., & Kapoor, B. (2018). Using Community Partnerships to Integrate Health and Social Services for High-Need, High-Cost Patients (Issue Brief). New York, NY: The Commonwealth Fund.
- Anderies, J. M., & Janssen, M. A. (2013). Robustness of Social-Ecological Systems: Implications for Public Policy. *Policy Studies Journal*, 41(3), 513–536.
- “Approaches to Cross-Sector Population Health Accountability (Issue Brief).” (2018). Discern Health. Washington, DC: AcademyHealth.
- Artz, K. W., & Brush, T. H. (2000). Asset Specificity, Uncertainty and Relational Norms: an Examination of Coordination Costs in Collaborative Strategic Alliances. *Journal of Economic Behavior & Organization*, 41(4), 337–362.
- ATLAS.ti: The Qualitative Data Analysis & Research Software. (2013). Version 7. Berlin: ATLAS.ti Scientific Software Development GmbH.
- Bacchi, C. (2009). *Analysing Policy: What’s the Problem Represented to Be?* (1st ed.). Pearson, Australia: Frenchs Forest, NSW.
- Bakken, E., Kindig, D., & Boufford, J. I. (2014). What “Community Building” Activities are Nonprofit Hospitals Reporting as Community Benefit? *Frontiers in Public Health Services and Systems Research*, 3(5).
- Baxter, P., & Jack, S. (2008). Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *The Qualitative Report*, 13(4), 544–559.
- Beck, U. (1992). *Risk Society: Towards a New Modernity*. London; Newbury Park, CA: Sage Publications.

- Bedoya, P., Neuhausen, K., Dow, A.W., Brooks, E.M., Mautner, D., Etz, R.S. (2018). Student Hotspotting: Teaching the Interprofessional Care of Complex Patients. *Acad Med*; 93(1):56–9.
- Benach, J., Malmusi, D., Yasui, Y., Martínez, J. M., & Muntaner, C. (2011). Beyond Rose’s Strategies: A Typology of Scenarios of Policy Impact on Population Health and Health Inequalities. *International Journal of Health Services*, 41(1), 1–9.
- Benjamin, L. M. (2008). Bearing More Risk for Results: Performance Accountability and Nonprofit Relational Work. *Administration & Society*, 39(8), 959–983.
- Benjamin, R. M. (2011). *National Prevention Strategy: America’s Plan for Better Health and Wellness*. Collingdale, PA: DIANE Publishing.
- Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, Health, and Cost. *Health Affairs*, 27(3), 759–769.
- Bevc, C. A., Retrum, J. H., & Varda, D. M. (2015a). New Perspectives on the “Silo Effect”: Initial Comparisons of Network Structures Across Public Health Collaboratives. *American Journal of Public Health*, 105, S230–S235.
- Bevc, C. A., Retrum, J. H., & Varda, D. M. (2015b). Patterns in PARTNERing across Public Health Collaboratives. *International Journal of Environmental Research and Public Health*, 12(10), 12412–12425.
- Biroscak, B. J., Schneider, T., Panzera, A. D., Bryant, C. A., McDermott, R. J., Mayer, A. B., ... Hovmand, P. S. (2014). Applying Systems Science to Evaluate a Community-Based Social Marketing Innovation: A Case Study. *Social Marketing Quarterly*, 20(4), 247–267.
- Bradley, E. H., Canavan, M., Rogan, E., Talbert-Slagle, K., Ndumele, C., Taylor, L., & Curry, L. A. (2016). Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, And Health Care, 2000–09. *Health Affairs*, 35(5), 760–768.
- Bradley, E., & Taylor, L. (2013). *The American Health Care Paradox: Why Spending More is Getting Us Less* (1st ed.). New York, NY: Public Affairs.
- Brodt, A., Kang, K., & Rein, A. (2017). *Toward Data-Driven, Cross-Sector, and Community-Led Transformation: An Environmental Scan of Select Programs* (Issue Brief). Washington, DC: AcademyHealth.

- Brown, G. K. (2017, September 28). Letter to the Oregon Health Policy Board. Retrieved from <http://www.oregon.gov/oha/OHPB/Documents/Gov.%20Brown%27s%20Letter%20to%20the%20Board.pdf>
- Bruch, S. K., Ferree, M. M., & Soss, J. (2010). From Policy to Polity: Democracy, Paternalism, and the Incorporation of Disadvantaged Citizens. *American Sociological Review*, 75(2), 205–226.
- Bruner, C. (1991). Thinking Collaboratively: Ten Questions and Answers to Help Policy Makers Improve Children’s Services (Education and Human Resources Consortium’s Series on Collaboration No. 3) (p. 33). Washington, DC: Institute of Education Sciences.
- Butler, S. M. (2015). Can Hospitals Help Create Healthy Neighborhoods? *JAMA*, 314(23), 2494–2495.
- Bylander, J. (2014). Healthy Futures Fund Links Housing, Health. *Health Affairs*, 33(11), 1966–1967.
- “CCO 2.0 Work Plan - Social Determinants of Health and Equity (Draft).” (2018, March 6). Oregon Health Policy Board. Salem, OR: Oregon Health Authority. Retrieved from <http://www.oregon.gov/oha/OHPB/CCODocuments/Work%20Plan%20-%20Health%20Equity%20and%20Social.pdf>
- Calabresi, G. (2008). *The Cost of Accidents: A Legal and Economic Analysis*. New Haven, CT: Yale University Press.
- Cantor, J., Tobey, R., Houston, K., & Greenberg, E. (2015). *Accountable Communities for Health: Strategies for Financial Sustainability*. San Francisco, CA: JSI Research & Training Institute, Inc.
- Carey, G., Malbon, E., Carey, N., Joyce, A., Crammond, B., & Carey, A. (2015). Systems Science and Systems Thinking for Public Health: a Systematic Review. *BMJ Open*, 5(e009002), 1–9.
- Carswell, P., Manning, B., Long, J., & Braithwaite, J. (2014). Building Clinical Networks: a Developmental Evaluation Framework. *BMJ Quality & Safety*, 23(5), 422–427.
- Cashman, S. B. (2016). Accountable Care Organizations: Embracing a New Population Health? *Medical Care*, 54(11), 967–969.

- Checkland, P. (2000). Soft Systems Methodology: a Thirty Year Retrospective. *Systems Research and Behavioral Science*, 17(1), S11–S58.
- Checkland, P., & Poulter, J. (2010). Soft Systems Methodology. In M. Reynolds & S. Holwell (Eds.), *Systems Approaches to Managing Change: A Practical Guide* (pp. 191–242). Springer London.
- Chen, C.-A., & Bozeman, B. (2012). Organizational Risk Aversion: Comparing the Public and Non-Profit Sectors. *Public Management Review*, 14(3), 377–402.
- Christensen, T. (2016). A framework for guiding efforts to reward value instead of volume. *International Journal of Health Economics and Management*, 16(2), 175–187.
- Churchman, C. W. (1970). Operations Research as a Profession. *Management Science*, 17(2), B37–B53.
- “Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health.” (2008). WHO Commission on Social Determinants of Health. Geneva, Switzerland: World Health Organization.
- “CMS’ Program History.” (2017). U.S. Dept. of Health and Human Services. Retrieved April 18, 2018, from <https://www.cms.gov/About-CMS/Agency-Information/History/index.html>
- Cooper, H. (2004). Medical Theories of Opiate Addiction’s Aetiology and their Relationship to Addicts’ Perceived Social Position in the United States: an Historical Analysis. *International Journal of Drug Policy*, 15(5), 435–445.
- Cooper, T. (2003). Critical Management, Critical Systems Theory and System Dynamics. *Systemic Practice & Action Research*, 5(3), 237–249.
- Cramer, G. R., Singh, S. R., Flaherty, S., & Young, G. J. (2016). The Progress of US Hospitals in Addressing Community Health Needs. *American Journal of Public Health*, 107(2), 255–261.
- Creswell, J. W. (2013). *Qualitative Inquiry & Research Design* (3rd ed). Thousand Oaks, CA: SAGE Publications.
- Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and Conducting Mixed Methods Research* (2nd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

- Crocker, T. D., & Shogren, J. F. (1994). Transferable Risks and the Technology of Environmental Conflict. *Society & Natural Resources*, 7(2), 181–188.
- Cross, J. E., Dickmann, E., Newman-Gonchar, R., & Fagan, J. M. (2009). Using Mixed-Method Design and Network Analysis to Measure Development of Interagency Collaboration. *American Journal of Evaluation*, 30(3), 310–329.
- Cutler, D. M., & Zeckhauser, R. J. (1998). Adverse Selection in Health Insurance. *Forum for Health Economics & Policy*, 1(1).
- Dawes, R. M. (1980). Social Dilemmas. *Annual Review of Psychology*, 31(1), 169–193.
- D’Este, P., Iammarino, S., Savona, M., & von Tunzelmann, N. (2012). What Hampers Innovation? Revealed Barriers Versus Deterring Barriers. *Research Policy*, 41(2), 482–488.
- DiMaggio, P. J., & Powell, W. W. (1983). The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields. *American Sociological Review*, 48(2), 147–160.
- Dillman, D. A. (2000). *Mail and Internet Surveys: The Tailored Design Method* (2nd ed.). New York, NY: Wiley.
- Eggleston, E. M., & Finkelstein, J. A. (2014). Finding the Role of Health Care in Population Health. *Journal of the American Medical Association*, 311(8), 797–798.
- “Elements That Support Payment Reform for Population Health: Payment and Financing Models (Issue Brief).” (2017b). Payment Reform for Population Health Initiative. Washington, DC: AcademyHealth.
- El-Sayed, A. M., & Galea, S. (2017). *Systems Science and Population Health* (1st ed.). New York, NY: Oxford University Press.
- Erickson, J., Milstein, B., Schafer, L., Pritchard, K. E., Levitz, C., Miller, C., & Cheadle, A. (2017). Progress Along the Pathway for Transforming Regional Health: A Pulse Check on Multi-Sector Partnerships. Morristown, NJ: ReThink Health.
- Exworthy, M. (1998). Localism in the NHS Quasi-Market. *Environment and Planning C: Government and Policy*, 16(4), 449–462.
- “Federal Low-Income Programs: Eligibility and Benefits Differ for Selected Programs Due to Complex and Varied Rules (Report to the Chairman, Committee on the

- Budget, U.S. Senate GAO-17-558).” (2017). United States Government Accountability Office.
- Feiock, R. C. (2013). The Institutional Collective Action Framework. *Policy Studies Journal*, 41(3), 397–425.
- “Financing Regional Health Transformation: The Mechanisms.” (2018). ReThink Health Initiative. Morristown, NJ: The Rippel Foundation.
- Fink, D. S., El-Sayed, A. M., & Galea, S. (2017). *Wrong Answers*. In *Systems Science and Population Health*. Oxford, UK: Oxford University Press.
- Fisher, M. P., & Elnitsky, C. (2012). Health and Social Services Integration: A Review of Concepts and Models. *Social Work in Public Health*, 27(5), 441–468.
- Fisher, E. S., Staiger, D. O., Bynum, J. P. W., & Gottlieb, D. J. (2007). Creating Accountable Care Organizations: The Extended Hospital Medical Staff. *Health Affairs*, 26(1), w44–w57.
- Flood, R. L. (1990). Liberating Systems Theory: Toward Critical Systems Thinking. *Human Relations*, 43(1), 49–75.
- Fraze, T., Lewis, V. A., Rodriguez, H. P., & Fisher, E. S. (2016). Housing, Transportation, And Food: How ACOs Seek to Improve Population Health by Addressing Nonmedical Needs Of Patients. *Health Affairs*, 35(11), 2109–2115.
- Freeman, R. E. (1984). *Strategic Management: a Stakeholder Approach*. Boston, MA: Pitman.
- Furlong, E. (1993). *Agenda-setting and policy design of the National Center for Nursing Research legislative amendment*. Ann Arbor, MI: ProQuest Dissertations Publishing.
- Galán, J. M., Łatek, M. M., & Rizi, S. M. M. (2011). Axelrod’s Metanorm Games on Networks. *PLoS ONE*, 6(5), e20474.
- Garg, A., Boynton-Jarrett, R., & Dworkin, P. H. (2016). Avoiding the Unintended Consequences of Screening for Social Determinants of Health. *JAMA*, 2016;316(8):813-814.
- Garg, A., Sandel, M., Dworkin, P. H., Kahn, R. S., & Zuckerman, B. (2012). From Medical Home to Health Neighborhood: Transforming the Medical Home into a

- Community-Based Health Neighborhood. *The Journal of Pediatrics*, 160(4), 535–536.e1.
- Garnick, D. W., Horgan, C. M., Hodgkin, D., Merrick, E. L., Goldin, D., Ritter, G., & Skwara, K. C. (2001). Risk Transfer and Accountability in Managed Care Organizations' Carve-out Contracts. *Psychiatric Services (Washington, D.C.)*, 52(11), 1502–1509.
- Garrison, L. P., & Neumann, P. J. (2015). Private Sector Risk-Sharing Agreements in the United States: Trends, Barriers, and Prospects. *The American Journal of Managed Care*, 21(9), 14.
- Geronimus, A. T. (2000). To Mitigate, Resist, or Undo: Addressing Structural Influences on the Health of Urban Populations. *American Journal of Public Health*, 90(6), 867.
- Gluckman, P., Hanson, M., Morton, S., & Pinal, C. (2005). Life-long Echoes - A Critical Analysis of the Developmental Origins of Adult Disease Model. *Biol. Neonate*, 87(2), 127–139.
- Gostin, L. O., & Powers, M. (2006). What Does Social Justice Require for The Public's Health? Public Health Ethics And Policy Imperatives. *Health Affairs*, 25(4), 1053–1060.
- Gottlieb, L., Tobey, R., Cantor, J., Hessler, D., & Adler, N. E. (2016). Integrating Social and Medical Data To Improve Population Health: Opportunities And Barriers. *Health Affairs*, 35(11), 2116–2123.
- Gregory, R., & Mendelsohn, R. (1993). Perceived Risk, Dread, and Benefits. *Risk Analysis*, 13(3), 259–264.
- Gunderson, L. H., & Holling, C. S. (Eds.). (2002). *Panarchy: Understanding Transformations in Human and Natural Systems*. Washington, D.C.: Island Press.
- Guo, F., Chang-Richards, Y., Wilkinson, S., & Li, T. C. (2014). Effects of project governance structures on the management of risks in major infrastructure projects: A comparative analysis. *International Journal of Project Management*, 32(5), 815–826.
- Hacker, J. S. (2004). Privatizing Risk without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States. *American Political Science Review*, 98(2), 243–260.

- Halley, A. A. (1997). Applications of Boundary Theory to the Concept of Service Integration in the Human Services. *Administration in Social Work*, 21(3–4), 145–168.
- Hargunani, D. (2017). Shared Measurement and Joint Accountability Across Health Care and Non-Health Care Sectors: State Opportunities to Address Population Health Goals. Princeton, NJ: State Health and Value Strategies.
- Hassett, S., & Austin, M. (1997). Service Integration: Something Old and Something New. *Administration in Social Work*, 21(3/4), 9–29.
- “Health IT Legislation.” (2016, May 12). Office of the National Coordinator for Health Information Technology. Retrieved March 1, 2018, from <https://www.healthit.gov/policy-researchers-implementers/health-it-legislation>
- “Health Related Services.” (2017). Office of Health Policy. Salem, OR: Oregon Health Authority.
- “Health Workforce Projections.” (2019, July) U.S. Health Resources & Services Administration, Bureau of Health Workforce. Available at: <https://bhw.hrsa.gov/health-workforce-analysis/research/projections>
- “Healthy People 2010: Understanding and Improving Health (No. 2nd ed.).” (2000). U.S. Dept. of Health and Human Services. Washington, DC: U.S. Government Printing Office.
- Heider, F., Kniffin, T., & Rosenthal, J. (2016). State Levers to Advance Accountable Communities for Health. Portland, ME: National Academy for State Health Policy.
- Henize, A. W., Beck, A. F., Klein, M. D., Adams, M., & Kahn, R. S. (2015). A Road Map to Address the Social Determinants of Health Through Community Collaboration. *Pediatrics*, 136(4), E993–E1001.
- Hertzman, C., & Power, C. (2003). Health and Human Development: Understandings from Life-Course Research. *Developmental Neuropsychology*, 24(2–3), 719–744.
- Hester, J. (2018). A Balanced Portfolio Model for Improving Health: Concept and Vermont’s Experience. *Health Affairs*, 37(4), 570–578.
- Hillman, A. J., Withers, M. C., & Collins, B. J. (2009). Resource Dependence Theory: A Review. *Journal of Management*, 35(6), 1404–1427.

- Hogan, L., Chang, D., Gratale, D., Gertel-Rosenberg, A. (September 6, 2018). Community Care Coordination Systems: Technology Supports (report). Washington, DC: Nemours Children's Health System.
- Hogg, R. A., & Varda, D. (2016). Insights into Collaborative Networks of Nonprofit, Private, And Public Organizations That Address Complex Health Issues. *Health Affairs*, 35(11), 2014–2019.
- Hollstein, B. (2011). Qualitative Approaches. In J. Scott & P. J. Carrington (Eds.), *The SAGE Handbook of Social Network Analysis* (pp. 404–416). SAGE.
- Homer, J., Milstein, B., Hirsch, G. B., & Fisher, E. S. (2016). Combined Regional Investments Could Substantially Enhance Health System Performance and Be Financially Affordable. *Health Affairs*, 35(8), 1435–1443.
- Horne, M. (2018). *Values in Social Work* (2nd ed.). London, UK: Routledge.
- Hovmand, P. S., & Gillespie, D. F. (2010). Implementation of Evidence-Based Practice and Organizational Performance. *Journal of Behavioral Health Services & Research*, 37(1), 79–94.
- Howard, R. A. (1989). The Foundations of Decision Analysis. In *Readings on the Principles and Applications of Decision Analysis* (Vol. 2). Menlo Park, CA: Strategic Decisions Group.
- Howard, M., Wu, Z., Caldwell, N., Jia, F., & König, C. (2016). Performance-Based Contracting in the Defence Industry: Exploring Triadic Dynamics Between Government, OEMs and Suppliers. *Industrial Marketing Management*, 59, 63–75.
- “Human Subjects Research: Social-Behavioral-Education (SBE) Basic.” (2015). CITI Program. Accessed September 21, 2015, from <https://about.citiprogram.org/en/course/human-subjects-research-2/>
- Hussey, P. S. (2007). Uninsured in America: Life and Death in the Land of Opportunity. *JAMA*, 298(6), 685–690.
- Indiana University Lilly Family School of Philanthropy, G. (2019). *Giving USA 2019: The Annual Report on Philanthropy for the Year 2018*. Chicago, IL: Giving USA Foundation.
- Ingram, R., Scutchfield, F. D., & Costich, J. F. (2015). Public Health Departments and Accountable Care Organizations: Finding Common Ground in Population Health. *American Journal of Public Health*, 105(5), 840–846.

- “Initiatives - Rides to Wellness.” (2017). U.S. Department of Transportation. Retrieved February 16, 2018, from <https://www.transit.dot.gov/ccam/about/initiatives>
- Institute of Medicine. (2011). *For the Public's Health: The Role of Measurement in Action and Accountability*. Washington, DC: National Academies Press.
- Ishihara Akifumi. (2017). Relational Contracting and Endogenous Formation of Teamwork. *The RAND Journal of Economics*, 48(2), 335–357.
- Jackson, M. C. (2010). Reflections on the Development and Contribution of Critical Systems Thinking and Practice. *Systems Research and Behavioral Science*, 27(2), 133–139.
- Jayasinghe, S. (2015). Social Determinants of Health Inequalities: Towards a Theoretical Perspective Using Systems Science. *International Journal for Equity in Health*, 14.
- Jean-Jacques, M., Mahmud, Y., Hamil, J., Kang, R., Duckett, P., & Yonek, J. C. (2016). Lessons Learned About Advancing Healthcare Equity from the Aligning Forces for Quality Initiative. *American Journal of Managed Care*, 22(12), S413–S422.
- Jenkins, S. P., Brandolini, A., Micklewright, J., & Nolan, B. (2012). *The Great Recession and the Distribution of Household Income*. Oxford, UK: Oxford University Press.
- Johnson, B. (1993). “The Mental Model” Meets “The Planning Process”: Wrestling with Risk Communication Research and Practice. *Risk Analysis*, 13(1), 5–8.
- Kadushin, C. (2012). *Understanding Social Networks: Theories, Concepts, and Findings*. New York, NY: Oxford University Press.
- Kadushin, C., Lindholm, M., Ryan, D., Brodsky, A., & Saxe, L. (2005). Why It Is So Difficult to Form Effective Community Coalitions. *City & Community*, 4(3), 255–275.
- Kahn-Best, R. (2012). Disease Politics and Medical Research Funding: Three Ways Advocacy Shapes Policy. *American Sociological Review*, 77(5), 780–803.
- Kahneman, D., & Tversky, A. (1979). Prospect Theory: An Analysis of Decision under Risk. *Econometrica*, 47(2), 263.
- Kania, J., & Kramer, M. (2011). Collective Impact. *Stanford Social Innovation Review*, (Winter 2011), 36–41.

- Kania, J., & Kramer, M. (2013). Embracing Emergence: How Collective Impact Addresses Complexity. *Stanford Social Innovation Review*.
- Katch, H., & Bailey, P. (2020, January 17). Medicaid Doesn't Pay for Housing. Here's What It Can Do To Help Meet Enrollees' Social Needs. *Health Affairs Blog*.
- Kim, K.-K., & Park, K. S. (2014). Transferring and Sharing Exchange-Rate Risk in a Risk-Averse Supply Chain of a Multinational Firm. *European Journal of Operational Research*, 237(2), 634–648.
- Kollock, P. (1998). Social Dilemmas: The Anatomy of Cooperation. *Annual Review of Sociology*, 24(1), 183–214.
- Kramer, M., Parkhurst, M., & Vaidyanathan, L. (2009). Breakthroughs in Shared Measurement and Social Impact. Boston, MA: FSG Social Impact Advisors.
- Kushner J & McConnell KJ. (2019). Addressing Social Determinants of Health through Medicaid: Lessons from Oregon. *J Health Polit Policy Law*, 44(6), 919-935.
- Lantz, P. M., Rosenbaum, S., Ku, L., & Iovan, S. (2016). Pay for Success and Population Health: Early Results from Eleven Projects Reveal Challenges and Promise. *Health Affairs*, 35(11), 2053–2061.
- Lasker, R. D., Weiss, E. S., & Miller, R. (2001). Partnership Synergy: A Practical Framework for Studying and Strengthening the Collaborative Advantage. *Milbank Quarterly*, 79(2), 179-205.
- Lawrence, P. R., & Lorsch, J. W. (1967). Differentiation and Integration in Complex Organizations. *Administrative Science Quarterly*, 12(1), 1–47.
- Lawrence, E., Stoker, R., & Wolman, H. (2013). The Effects of Beneficiary Targeting on Public Support for Social Policies. *Policy Studies Journal*, 41(2), 199–216.
- Lax, D. A., & Sebenius, J. K. (1986). *The Manager as Negotiator: Bargaining for Cooperation and Competitive Gain*. New York, NY: Free Press.
- Lendaris, G. G. (1986). On Systemness and the Problem Solver: Tutorial Comments. *Systems, Man and Cybernetics Society*, SMC-16(4).
- Lindau, S. T., Makelarski, J., Abramsohn, E., Beiser, D. G., Escamilla, V., Jerome, J., ... Miller, D. C. (2016). CommunityRx: A Population Health Improvement Innovation That Connects Clinics to Communities. *Health Affairs*, 35(11), 2020–2029.

- Linden, R. M. (2002). *Working Across Boundaries: Making Collaboration Work in Government and Nonprofit Organizations* (1 edition). San Francisco, CA: Jossey-Bass.
- Litt, J., Varda, D., Reed, H., Retrum, J., Tabak, R., Gustat, J., & Tompkins, N. O. (2015). How to Identify Success Among Networks That Promote Active Living. *American Journal of Public Health*, 105(11), 2298–2305.
- Liu, J., & Faure, M. (2018). Risk-Sharing Agreements to Cover Environmental Damage: Theory and Practice. *International Environmental Agreements: Politics, Law and Economics*, 18(2), 255–273.
- Lloyd, W. F. (1833). Two lectures on the checks to population delivered before the University of Oxford, in Michaelmas term 1832. London, UK: J.H. Parker.
- Lo Nigro, G., & Abbate, L. (2011). Risk Assessment and Profit Sharing in Business Networks. *International Journal of Production Economics*, 131(1), 234–241.
- Løkke, A.-K., & Sørensen, P. D. (2014). Theory Testing Using Case Studies. *Electronic Journal of Business Research Methods*, 12(1).
- Lushniak, B. D., Alley, D. E., Ulin, B., & Graffunder, C. (2015). The National Prevention Strategy: Leveraging Multiple Sectors to Improve Population Health. *American Journal of Public Health; Washington*, 105(2), 229–231.
- Machledt, D. (2017, November 29). *Addressing the Social Determinants of Health Through Medicaid Managed Care*. New York, NY: The Commonwealth Fund.
- Marcos, J., & Prior, D. D. (2017). Buyer-supplier relationship decline: A norms-based perspective. *Journal of Business Research*, 76, 14–23.
- Martin, L., Nelson, E., Rakover, J., & Chase, A. (2016). *Whole System Measures 2.0: A Compass for Health System Leaders*. Cambridge, MA: Institute for Healthcare Improvement.
- Martinez-Vidal, E., & Kennedy, S. (2016). *Payment Reform for Population Health*. Washington, DC: AcademyHealth.
- Martinez-Vidal, E., Kennedy, S., & Smith, S. (2017). *Four Elements that Influence Payment Reform for Population Health*. Washington, DC: AcademyHealth.

- Mays, G. P., Mamaril, C. B., & Timsina, L. R. (2016). Preventable Death Rates Fell Where Communities Expanded Population Health Activities Through Multisector Networks. *Health Affairs*, 35(11), 2005–2013.
- McCain, R. (2014). *Game Theory: A Nontechnical Introduction to the Analysis of Strategy* (3rd ed.). Singapore: World Scientific Publishing Company.
- McConnell, K. J. (2016). Oregon’s Medicaid Coordinated Care Organizations. *JAMA*, 315(9), 869–870.
- McDaniel, R. R., Lanham, H. J., & Anderson, R. A. (2009). Implications of Complex Adaptive Systems Theory for the Design of Research on Health Care Organizations. *Health Care Management Review*, 34(2), 191–199.
- McGinnis, J. M., Williams-Russo, P., & Knickman, J. R. (2002). The Case for More Active Policy Attention to Health Promotion. *Health Affairs*, 21(2), 78–93.
- McGovern, L., Miller, G., & Hughes-Cromwick, P. (2014). The Relative Contribution of Multiple Determinants to Health Outcomes (Health Policy Brief). *Health Affairs*.
- McGraw, D. (2014). Appendix B: Privacy Concerns Related to Inclusion of Social and Behavioral Determinants of Health in Electronic Health Records. In *Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2*. Washington, DC: National Academies Press.
- McKenna, T. (2017). Calling on Healthcare and Human Services Partnerships: Help Advance Research to Benefit Well-Being of US Communities (Blog Post, January 4th, 2017). New York, NY: The Nonprofit Finance Fund.
- Meadows, D. H. (1999). *Leverage Points: Places to Intervene in a System*. Norwich, VT: Academy for Systems Change.
- “Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs.” (2016). The MITRE Corporation. MacLean, VA: Health Care Payment Learning & Action Network.
- “Medicaid 1115 Waiver.” (n.d.). Oregon Health Authority. Retrieved March 10, 2018, from <http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/pages/index.aspx>
- Messer, L. C., Boone-Heinonen, J., Mponwane, L., Wallack, L., & Thornburg, K. L. (2015). Developmental Programming: Priming Disease Susceptibility for Subsequent Generations. *Current Epidemiology Reports*, 2(1), 37–51.

- Midgley, G., Johnson, M. P., & Chichirau, G. (2018). What is Community Operational Research? *European Journal of Operational Research*, 268(3), 771–783.
- Midgley, G., Munlo, I., & Brown, M. (1998). The Theory and Practice of Boundary Critique: Developing Housing Services for Older People. *Journal of the Operational Research Society*, 49(5), 467–478.
- Mikkelsen, L., & Haar, W. L. (2015). *Accountable Communities for Health: Opportunities and Recommendations*. Oakland, CA: The Prevention Institute.
- Milbourne, L. (Forthcoming). A Pawn in Their Game? A Critical Perspective on Collaboration. In A. M. Eikenberry, R. M. Mirabella, & B. Sandberg (Eds.), *Reframing Nonprofit Management: Democracy, Inclusion and Social Justice*. Irvine, CA: Melvin & Leigh.
- Miller, G. J., & Whitford, A. B. (2002). Trust and Incentives in Principal-Agent Negotiations: The ‘Insurance/Incentive Trade-Off.’ *Journal of Theoretical Politics*, 14(2), 231–267.
- Milliken, F. J. (1987). Three Types of Perceived Uncertainty about the Environment: State, Effect, and Response Uncertainty. *The Academy of Management Review*, 12(1), 133–143.
- Mintzberg, H. (1980). Structure in 5’s: A Synthesis of the Research on Organization Design. *Management Science*, 26(3), 322–341.
- Mitchell, R. K., van Buren III, H. J., Greenwood, M., & Freeman, R. E. (2015). Stakeholder Inclusion and Accounting for Stakeholders (SSRN Scholarly Paper No. ID 2668867). Rochester, NY: Social Science Research Network.
- Morgan, D. L. (1998). Practical Strategies for Combining Qualitative and Quantitative Methods: Applications to Health Research. *Qualitative Health Research*, 8(3), 362–376.
- Morris, J. N., Heady, J. A., Raffle, P. a. B., Roberts, C. G., & Parks, J. W. (1953). Coronary Heart-Disease and Physical Activity of Work. *The Lancet*, 262(6795), 1053–1057.
- “Multisector Community Health Partnerships: Potential Opportunities and Challenges: Proceedings of a Workshop—in Brief.” (2017). National Academies of Sciences, Engineering, and Medicine. Washington, DC: The National Academies Press.

- Navlakha, S., & Bar-Joseph, Z. (2014). Distributed Information Processing in Biological and Computational Systems. *Commun. ACM*, 58(1), 94–102.
- Never, B., & de Leon, E. (2017). The Cost of Accountability for Small Human Service Contractors. *Human Service Organizations: Management, Leadership & Governance*, 41(4), 403–415.
- Nguyen D. A., Garvin M. J., & Gonzalez E. E. (2018). Risk Allocation in U.S. Public-Private Partnership Highway Project Contracts. *Journal of Construction Engineering and Management*, 144(5), 04018017.
- Nichols, L. M., & Taylor, L. A. (2018). Social Determinants as Public Goods: A New Approach to Financing Key Investments in Healthy Communities. *Health Affairs*, 37(8), 1223–1230.
- Nuno-Solinis, R., Shortell, S. M., Scheffler, R. M., & Kellogg, M. A. (2019, July 9). Implementing Population Health in the US: Lessons from Spain. *Health Affairs Blog*.
- “Office of Safe and Healthy Students Programs.” (2017). U.S. Dept. of Education. Retrieved April 18, 2018, from <https://www2.ed.gov/about/offices/list/oese/oshs/oshsprograms.html#safe>
- “Office of Violence Against Women: Grant Programs.” (2017, December 2). U.S. Dept. of Justice. Retrieved February 16, 2018, from <https://www.justice.gov/ovw/grant-programs#about>
- Olson, M. (1965). *The Logic of Collective Action: Public Goods and the Theory of Groups*. Cambridge, Mass.: Harvard University Press.
- Oregon Health Policy Board. (2018). “CCO 2.0 Recommendations of the Oregon Health Policy Board.” Oregon Health Authority Health Policy & Analytics Division.
- “ORPRN E-News – June 2017.” (2017). Oregon Rural Practice-Based Research Network. Retrieved from <http://www.ohsu.edu/xd/outreach/oregon-rural-practice-based-research-network/news-and-events/upload/06-2017-E-News.pdf>
- Ostrom, E. (2015). *Governing the Commons: The Evolution of Institutions for Collective Action* (Canto Classics edition). Cambridge, UK: Cambridge University Press.
- Page, S. (2005). What’s New about the New Public Management? *Administrative Change in the Human Services*. *Public Administration Review*, 65(6), 713–727.

- Palmer, T. B., & Wiseman, R. M. (1999). Decoupling Risk Taking from Income Stream Uncertainty: A Holistic Model of Risk. *Strategic Management Journal*, 20(11), 1037–1062.
- Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).
- Pattberg, P., & Widerberg, O. (2016). Transnational Multistakeholder Partnerships for Sustainable Development: Conditions for Success. *Ambio*, 45(1), 42–51.
- Perla, R., & Onie, R. (2016, March 2). Accountable Health Communities and Expanding Our Definition of Health Care (Blog Post). Washington, DC: AcademyHealth.
- Perrow, C. (2014). *Complex Organizations: A Critical Essay*. (4th ed.). Brattleboro, VT: Echo Point Books and Media.
- Pfeffer, J., & Salancik, G. R. (1978). *The External Control of Organizations. A Resource Dependence Perspective*. New York, NY: Harper and Row.
- Plough, A. L. (2015). Building a Culture of Health: A Critical Role for Public Health Services and Systems Research. *American Journal of Public Health*, 105(S2), S150–S152.
- “Population Health Integration in the Vermont Health Care Innovation Project: ACOs, TACOs, and Accountable Communities for Health.” (2015). Vermont Population Health Work Group. Montpelier, VT: State of Vermont Health Care Innovation Project.
- Powell, R. E., Doty, A., Casten, R. J., Rovner, B. W., & Rising, K. L. (2016). A Qualitative Analysis of Interprofessional Healthcare Team Members’ Perceptions of Patient Barriers to Healthcare Engagement. *BMC Health Services Research*, 16, 493.
- Poundstone, W. (1992). *Prisoner’s dilemma* (1st ed.). New York: Doubleday.
- “Programs of HUD - Major Mortgage, Grant, Assistance, and Regulatory Programs.” (2017). U.S. Dept. of Housing and Urban Development. Retrieved from <https://www.hud.gov/sites/dfiles/Main/documents/HUDPrograms2017.pdf>
- Purnell, T. S., Calhoun, E. A., Golden, S. H., Halladay, J. R., Krok-Schoen, J. L., Appelhans, B. M., & Cooper, L. A. (2016). Achieving Health Equity: Closing the Gaps In Health Care Disparities, Interventions, And Research. *Health Affairs*, 35(8), 1410–1415.

- Qualtrics. (Version July 2018). Provo, UT: Qualtrics.
- Rainie, L., Keeter, S., & Perrin, A. (2019). *Trust and Distrust in America*. Washington, DC: Pew Research Center.
- Reger, R. K., & Sigismund-Huff, A. (1993). Strategic Groups: A Cognitive Perspective. *Strategic Management Journal*, 14(2), 103–123.
- Reno, J. (2013, November 1). VA Stops Releasing Data on Injured Vets as Total Reaches Grim Milestone [EXCLUSIVE]. *International Business Times*. Retrieved from <http://www.ibtimes.com/va-stops-releasing-data-injured-vets-total-reaches-grim-milestone-exclusive-1449584>
- “Report to the California Health and Human Services Agency Secretary, Diana S. Dooley: Recommendations for the California State Healthcare Innovation Plan Accountable Communities for Health Initiative.” (2015). State of California Innovation Plan AHC Workgroup. Sacramento, CA: California Health and Human Services Agency.
- Rittel, H. W., & Webber, M. M. (1973). Dilemmas in a General Theory of Planning. *Policy Sciences*, 4(2), 155–169.
- Robinson, J. C. (1994). The Changing Boundaries of the American Hospital. *The Milbank Quarterly*, 72(2), 259–275.
- Roehrich, J. K., & Caldwell, N. D. (2012). Delivering Integrated Solutions in the Public Sector: The Unbundling Paradox. *Industrial Marketing Management*, 41(6), 995–1007.
- Rogan, E., & Bradley, E. (2016). Investing in Social Services for States’ Health: Identifying and Overcoming the Barriers. New York, NY: Milbank Memorial Fund.
- Roman, J. (2015). Solving the Wrong Pockets Problem: How Pay for Success Promotes Investment in Evidence-Based Best Practices. Washington, DC: Urban Institute.
- Rose, G. (2001). Sick Individuals and Sick Populations. *International Journal of Epidemiology*, 30(3), 427–432.
- Rosenthal, M. B. (2000). Risk Sharing and the Supply of Mental Health Services. *Journal of Health Economics*, 19(6), 1047–1065.

- 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, 369–402.
- RStudio. (2018). (Version 1.1.453). Boston, MA: RStudio.
- Russ-Eft, D., & Preskill, H. (2009). *Evaluation in Organizations: A Systematic Approach to Enhancing Learning, Performance and Change* (2nd ed). New York, NY: Basic Books.
- Russell, J., Greenhalgh, T., Byrne, E., & McDonnell, J. (2008). Recognizing Rhetoric in Health Care Policy Analysis. *Journal of Health Services Research & Policy*, 13(1), 40–46.
- Sabatier, P. A., & Weible, C. M. (Eds.). (2014). *Theories of the Policy Process* (3rd ed.). Boulder, CO: Westview Press.
- Samuelson, P. A. (1954). The Pure Theory of Public Expenditure. *The Review of Economics and Statistics*, 36(4), 387–389.
- Sandberg, S. F., Erikson, C., Owen, R., Vickery, K. D., Shimotsu, S. T., Linzer, M., ... DeCubellis, J. (2014). Hennepin Health: A Safety-Net Accountable Care Organization for The Expanded Medicaid Population. *Health Affairs*, 33(11), 1975–1984.
- Sandman, P. M. (1989). Hazard Versus Outrage in the Public Perception of Risk. In *Effective Risk Communication* (pp. 45–49). Boston, MA: Springer Publishing.
- Savage, I. (1993). Demographic Influences on Risk Perceptions. *Risk Analysis*, 13(4), 413–420.
- Schneider, A., & Ingram, H. (1993). Social Construction of Target Populations: Implications for Politics and Policy. *American Political Science Review*, 87(2), 334+.
- Schneider, A., Ingram, H., & deLeon, P. (2014). Democratic Policy Design: Social Construction of Target Populations. In P. A. Sabatier & C. M. Weible (Eds.), *Theories of the Policy Process* (3rd ed., pp. 105–149). Boulder, CO: Westview Press.
- Scott, R. W. (1987). *Organizations: Rational, Natural and Open Systems* (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall, Inc.

- Scott, W., & Meyer, J. (1991). The Organization of Societal Sectors: Propositions and Early Evidence. *The New Institutionalism and Organizational Analysis* (pp. 108–140). Chicago, IL: University of Chicago Press.
- Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S., & Marmar, C. (2007). Bringing the War Back Home: Mental Health Disorders Among 103,788 US Veterans Returning from Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities. *Archives of Internal Medicine*, 167(5), 476–482.
- Selber, K., & Austin, D. M. (1997). Mary Parker Follett: Epilogue to or Return of a Social Work Management Pioneer? *Administration in Social Work*, 21(1), 1–15.
- Selsky, J. W., & Parker, B. (2005). Cross-Sector Partnerships to Address Social Issues: Challenges to Theory and Practice. *Journal of Management*, 31(6), 849–873.
- Sia, C., Tonniges, T. F., Osterhus, E., & Taba, S. (2004). History of the Medical Home Concept. *Pediatrics*, 113(5), 1473–1478.
- 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.
- Sieng, P. (2016, September 20). Call to Action: Data-Driven Justice Initiative, Disrupting Cycle of Incarceration (Blog post). Salem, OR: Association of Oregon Counties.
- Skocpol, T. (1995). *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*. Cambridge, MA: Harvard University Press.
- Solar, O., & Irwin, A. (2010). Historical Trajectory. In *A Conceptual Framework for Action on The Social Determinants of Health: Debates, Policy & Practice, Case Studies*. (pp. 10–11). Geneva: World Health Organization.
- Spencer, A., Lloyd, J., & McGinnis, T. (2015). *Using Medicaid Resources to Pay for Health-Related Supportive Services: Early Lessons* (Brief). Trenton, NJ: The Center for Healthcare Strategies.
- Stange, K. C. (2009a). The Problem of Fragmentation and the Need for Integrative Solutions. *Annals of Family Medicine*, 7(2), 100–103.
- Stange, K. C. (2009b). A Science of Connectedness. *Annals of Family Medicine*, 7(5), 387–395.

- Stange, K. C., & Ferrer, R. L. (2009). The Paradox of Primary Care. *Annals of Family Medicine*, 7(4), 293–299.
- Stange, K. C., Ferrer, R. L., & Miller, W. L. (2009). Making Sense of Health Care Transformation as Adaptive-Renewal Cycles. *Annals of Family Medicine*, 7(6), 484–487.
- Stecker, E. C. (2013). The Oregon ACO Experiment — Bold Design, Challenging Execution. *New England Journal of Medicine*, 368(11), 982–985.
- Steinacker, A. (2004). Game-Theoretic Models of Metropolitan Cooperation. In R. C. Feiock, *Metropolitan Governance: Conflict, Competition and Cooperation* (pp. 46–66). Washington, DC: Georgetown University Press.
- Steinmo, S., & Watts, J. (1995). It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America. *Journal of Health Politics, Policy and Law*, 20(2), 329–372.
- Stone, D. (2008). *The Samaritan's Dilemma: Should Government Help Your Neighbor?* New York, NY: Nation Books.
- Stoto, M. A., Klaiman, T., & Davis, M. (2018). *A Community Health Needs Assessment Environment Scan* (SSRN Scholarly Paper ID 3230259). Rochester, NY: Social Science Research Network.
- “Striving Toward A Culture of Health: How Do Care And Costs For Non-Medical Needs Get Factored Into Alternative Payment Models? (Workshop Summary and Lessons Learned).” (2017). Payment Reform for Population Health Initiative. Austin, TX: AcademyHealth, Network for Regional Healthcare Improvement, and Robert Wood Johnson Foundation.
- Summer, M. (2013). Financial Contagion and Network Analysis. *Annual Review of Financial Economics*, 5(1), 277–297.
- Szreter, S. (2003). The Population Health Approach in Historical Perspective. *American Journal of Public Health*, 93(3), 421–431.
- TapeACall.com (Version 2019). (n.d.). [Computer software]. New York, NY: TelTech Systems, Inc.
- Temi.com (Version 2019). (n.d.). [Computer software]. San Francisco, CA: Temi.

- Thorstenson, K. (2015, June 19). BUILD Health Challenge Announces Portland as one of 18 Awardees from Across the Nation. The Lund Report. Retrieved from <https://www.thelundreport.org/content/build-health-challenge-announces-portland-one-18-awardees-across-nation>
- Torugsa, N., & Arundel, A. (2017). Rethinking the Effect of Risk Aversion on the Benefits of Service Innovations in Public Administration Agencies. *Research Policy*, 46(5), 900–910.
- Trujillo, M. D., & Plough, A. (2016). Building a Culture of Health: A New Framework and Measures for Health and Health Care in America. *Social Science & Medicine*, 165, 206–213.
- Ulrich, W. (1983). *Critical Heuristics of Social Planning: a New Approach to Practical Philosophy*. Bern: P. Haupt.
- Ulrich, W. (2012). Operational Research and Critical Systems Thinking—an Integrated Perspective Part 1: OR as Applied Systems Thinking. *Journal of the Operational Research Society*, 63(9).
- Ulrich, W., & Reynolds, M. (2010). Critical Systems Heuristics. In Reynolds, Martin & S. Holwell (Eds.), *Systems Approaches to Managing Change: A Practical Guide* (pp. 243–292). London, UK: Springer.
- Valente, T. W., Chou, C. P., & Pentz, M. A. (2007). Community Coalitions as a System: Effects of Network Change on Adoption of Evidence-Based Substance Abuse Prevention. *American Journal of Public Health*, 97(5), 880–886.
- Varda, D. M., & Retrum, J. H. (2015). Collaborative Performance as a Function of Network Members' Perceptions of Success. *Public Performance & Management Review*, 38(4), 632–653.
- Varda, D., Shoup, J. A., & Miller, S. (2012). A Systematic Review of Collaboration and Network Research in the Public Affairs Literature: Implications for Public Health Practice and Research. *American Journal of Public Health*, 102(3), 564–571.
- Walker, G. (2000). Urban Planning, Hazardous Installations, and Blight: An Evaluation of Responses to Hazard — Development Conflict. *Environment and Planning C: Government and Policy*, 18(2), 127–143.

- Warren, R. L., Rose, S. M., & Bergunder, A. F. (1974). *The Structure of Urban Reform: Community Decision Organizations in Stability and Change*. Lexington, MA: Lexington Books.
- Watson, E. R., & Foster-Fishman, P. G. (2013). The Exchange Boundary Framework: Understanding the Evolution of Power within Collaborative Decision-Making Settings. *American Journal of Community Psychology*, 51(1–2), 151–163.
- Watts, D. J., Dodds, P. S., & Newman, M. E. J. (2002). Identity and Search in Social Networks. *Science*, 296, 1302–1305.
- Weber, J. M., Kopelman, S., & Messick, D. M. (2004). A Conceptual Review of Decision Making in Social Dilemmas: Applying a Logic of Appropriateness. *Personality and Social Psychology Review*, 8(3), 281–307.
- Weil, A. R. (2016). Defining and Measuring A Culture of Health. *Health Affairs*, 35(11), 1947–1947.
- Westley, F., & Vredenburg, H. (1997). Interorganizational Collaboration and the Preservation of Global Biodiversity. *Organization Science*, 8(4), 381–403.
- Wholey, D. R., Gregg, W., & Moscovice, I. (2009). Public Health Systems: a Social Networks Perspective. *Health Services Research*, 44(5 Pt 2), 1842–1862.
- Williams, T. (2002). *Modelling Complex Projects*. West Sussex, UK: John Wiley & Sons, Ltd.
- Williamson, O. E. (1973). Markets and Hierarchies: Some Elementary Considerations. *The American Economic Review*, 63(2), 316–325.
- Williamson, O. E. (2002). The Theory of the Firm as Governance Structure: From Choice to Contract. *Journal of Economic Perspectives*, 16(3), 171–195.
- Wood, D. J., & Gray, B. (1991). Toward a Comprehensive Theory of Collaboration. *Journal of Applied Behavioral Science*, 27(2), 139–162.
- Wright, K., Farris-Berg, K., & Becker, S. (2016). *How Do Institutional Financing Structures for Meeting Social Needs Get Their Start?* St. Louis, MO: ReThink Health.
- Wyatt, R., Laderman, M., Botwinick, L., Mate, K., & Whittington, J. (2016). *Institute for Healthcare Improvement: Achieving Health Equity: A Guide for Health Care*

Organizations (IHI White Paper). Cambridge, MA: Institute for Healthcare Improvement.

Yin, R. K. (2009). *Case Study Research: Design and Methods* (4th ed.). Thousand Oaks, CA: SAGE Publications.

Zexian, Y., & Xuhui, Y. (2010). A Revolution in the Field of Systems Thinking—a Review of Checkland’s System Thinking. *Systems Research and Behavioral Science*, 27(2), 140–155.

Zhou, L., Lü, K., & Liu, W. (2013). Game Theory-Based Influence Diagrams. *Expert Systems*, 30(4), 341–351.

Zimmerman, F. J. (2013). Habit, Custom, and Power: A Multi-Level Theory of Population Health. *Social Science & Medicine*, 80, 47–56.

Appendix A: Invitation to Participate in Research

To: <email address of prospective interviewee>

From: Dr. Bruce Goldberg, Professor, OHSU-PSU School of Public Health and Senior Associate Medical Director, ORPRN

Subject: Invitation to participate in research on cross-sector health partnerships

Dear <name>,

I am reaching out to introduce you to Shauna Petchel (cc'd) and forward an invitation to participate in research that Ms. Petchel is conducting toward her doctoral dissertation at the OHSU-PSU School of Public Health.

Request: Ms. Petchel is interested in connecting with your organization because of your involvement in Accountable Health Communities. This research is not tied to ORPRN or Accountable Health Communities and your participation would be strictly voluntary.

Ms. Petchel is seeking one person from your organization who is a) in a leadership or decision-making role with respect to community partnerships, and b) is willing to share their perspective on the organizational impacts of cross-sector collaboration.

Participation in this research would involve:

- participation in a confidential 1-hour interview (in person or by phone)
- completion of a brief ten-question survey about your organization (to be completed online prior to the interview)

About the study: The purpose of Ms. Petchel's research is to understand the experiences of both health care and non-health care organizations engaged in cross-sector initiatives addressing social determinants of health. This research will explore how the benefits and risks of cross-sector health partnerships such as Accountable Health Communities may differently affect the organizations that engage in them. Ms. Petchel's research has been approved by PSU's Institutional Review Board (IRB) and is being supervised by her dissertation committee members at the OHSU-PSU School of Public Health: Dr. Sherril Gelmon (chair), Dr. Neal Wallace, Dr. Billie Sandberg and myself.

Are you willing to participate in this research? If so, please respond in the next 1-2 weeks or direct any questions to Ms. Petchel via this email or by calling her [redacted]. If another person at your organization would be better suited to participate in this research, please forward this invitation to them (but please do not forward this invitation *outside* your organization).

Thank you for considering participation in this study.

Appendix B: Invitation Reminder

To: <email address of prospective interviewee>
From: Shauna Petchel
Subject: Reminder: Invitation to participate in research on cross-sector health partnerships

Dear <name>,
I am following up on a recent email introduction from Dr. Bruce Goldberg. I am interested in connecting with your organization because of your involvement in the Accountable Health Communities project in Oregon.

I am a doctoral candidate at the OHSU-PSU School of Public Health conducting research toward my dissertation under the supervision of Dr. Sherril Gelmon. This research is not tied to ORPRN or Accountable Health Communities and your participation would be strictly voluntary.

The purpose of this research is to understand the experiences of both health care and non-health care organizations engaged in cross-sector initiatives addressing social determinants of health. This research will explore how the benefits and risks of cross-sector health partnerships such as Accountable Health Communities may differently affect the organizations that engage in them. The research has been approved by PSU's Institutional Review Board.

I am seeking one person from your organization who 1) is in a leadership or decision-making role with respect to community partnerships, and 2) is willing to share their perspective on the organizational impacts of cross-sector collaboration. Participation in this research would involve:

- participation in a confidential 1-hour interview (in person or by phone)
- completion of a brief, ten-question survey about your organization to be completed online prior to the interview

Are you willing to participate in this research? If so, please respond this week via this email or by calling me at [redacted]. If another person at your organization would be better suited to participate in this research, please forward this invitation to them (but please do not forward this invitation *outside* your organization). I am also happy to answer any questions you have about the research.

Thank you for considering participation in this study.

Appendix C: Consent Form

About This Research

You are invited to participate in research being conducted by Shauna Petchel, a doctoral student at the OHSU-PSU School of Public Health, under the supervision of Dr. Sherril Gelmon.

The purpose of this research is to understand the experiences of both health care and non-health care organizations engaged in cross-sector networks addressing social determinants of health. You were identified as a possible participant in this research because of your organization's involvement (or potential involvement) with the Accountable Health Communities initiative, and because you are involved in decision-making about your organization's community partnerships.

This form will explain the research study and the possible benefits and risks to you. Participation in this research consists of a one-hour interview where you will be asked a series of questions about cross-sector partnerships. You will be asked to share your opinion on these partnerships, any experiences you have with them, and how these experiences have affected your organization. There are no right or wrong answers to these questions, and you may decline to answer any questions you are not comfortable discussing.

If you consent to participate, your responses will be confidential. The interview will be audio-recorded, transcribed and stored in a secure, password-protected database to help with later qualitative analysis. You will be assigned a study identification number to be used in place of your name in the research database and study records. Your identity and any personally identifying information will not appear in the interview transcripts or any published documents arising from this research. Research records connected to you will be stored for not more than ten years and then destroyed. Only Ms. Petchel and Dr. Sherril Gelmon, her dissertation research chair, will have access to the study database. PSU's Institutional Review Board (a committee that protects the rights of research subjects) may also inspect records related to this study, and there may be times when we are required by law to share your information. It is the investigator's legal obligation to report child abuse, child neglect, elder abuse, harm to self or others or any life-threatening situation to the appropriate authorities.

You may not receive any direct benefit from participating in this research, but the study may contribute to knowledge about cross-sector partnerships that could help others in the future. Your participation is strictly voluntary. Some of the questions asked during the interview may be sensitive and make you feel uncomfortable. You can refuse to answer any question(s) or discontinue the interview at any time. You do not give up any legal rights by signing this consent form and taking part in this study. While certain ORPRN staff have provided input to the researcher in developing this study, this research is not

affiliated with ORPRN or Accountable Health Communities. Consenting or declining to participate in this study will not affect your relationship with ORPRN or your eligibility for any benefits or services.

If you have questions or concerns about your participation in this study, you may contact: Shauna Petchel (researcher), [redacted] or [redacted]
Dr. Sherril Gelmon (faculty supervisor and principal investigator), [redacted] or [redacted].

If you have concerns about your rights as a research participant, please contact the Portland State University Office for Research Integrity (ORI) at (503) 725-2227 or 1 (877) 480-4400 or email hsrrc@pdx.edu. The ORI is the office that supports the PSU Institutional Review Board (IRB). The IRB is a group of people from PSU and the community who provide independent oversight of safety and ethical issues related to research involving human participants. For more information, you may also access the IRB website at <https://sites.google.com/a/pdx.edu/research/integrity>.

Consent to Participate

You are making a decision whether to participate in this study. Your signature indicates that you have read the information provided to you and agree to take part in this study. By signing this consent form, you are not waiving any of your legal rights as a research participant. The researcher will provide you with an electronic copy of this form for your own records.

Participant:

Signature

Name (printed)

Date

Person obtaining consent:

This research study has been explained to the participant and all of his/her questions have been answered. The participant understands the information described in this consent form and freely consents to participate.

Signature

Name (printed)

Date

Appendix D: Survey Questionnaire

Survey Consent (landing page after email link)

Please review all of the information on this page before proceeding via the link at the bottom of the page. You are making a decision whether or not to participate in a research study. This page contains information about your rights as a research participant.

About this Research: This research is being conducted by Shauna Petchel, a doctoral candidate at the OHSU-PSU School of Public Health, under the supervision of Dr. Sherril Gelmon. The purpose of this research is to understand the experiences of both health care and non-health care partners engaged in cross-sector and collective impact initiatives addressing social determinants of health.

You were invited to participate in this research because of your organization's involvement with Accountable Health Communities. This case study of Accountable Health Communities in Oregon will explore how the benefits and risks of cross-sector health partnerships may differently affect the partners who engage in them, and the implications for initiatives that aim to accelerate cross-sector work.

You may not receive any direct benefit from participating in this research, but the study may contribute to knowledge about cross-sector partnerships that could help others in the future.

If you consent to participate, you may discontinue the survey at any time or decline to answer any questions without penalty or loss of any benefits to which you are otherwise entitled. This research is not affiliated with the Oregon Rural Practice-based Research Network (ORPRN) or Accountable Health Communities. Your participation is voluntary and declining to participate will not result in any penalties or loss of benefits to which you are otherwise entitled.

About this Survey: The estimated time to complete this survey is 15 minutes. The survey consists of 10 questions (most of which are multiple choice) related to your organization's activities and partnerships. The requested information is of a public nature and presents minimal, if any, risk to you and your organization.

You and your organization will not be personally identified in any published documents arising from this survey. You will be assigned a study identification number to be used in place of your name in the research database. Only the student researcher and her supervisor will have access to the raw survey data, which will be electronically stored in a password-protected platform. PSU's Institutional Review Board (a committee that protects the rights of research subjects) may also inspect records related to this study, and there may be times when we are required by law to share your information.

If you have questions or concerns about your participation in this study, you may contact: Shauna Petchel (student researcher), (702) 580-8989 or spetchel@pdx.edu Dr. Sherril Gelmon (faculty supervisor and principal investigator), (503) 725-3044 or gelmons@pdx.edu

If you have concerns about your rights as a research participant, please contact the Portland State University Office for Research Integrity (ORI) at (503) 725-2227 or 1 (877) 480-4400 or email hsrrc@pdx.edu. The ORI is the office that supports the PSU Institutional Review Board (IRB). The IRB is a group of people from PSU and the community who provide independent oversight of safety and ethical issues related to research involving human participants. For more information, you may also access the IRB website at <https://sites.google.com/a/pdx.edu/research/integrity>.

By clicking “continue” you are indicating that you understand the information provided above and agree to participate in this research.

<<Continue >>

Survey Questions

1. What is your organization name?

Enter your organization here

2. Does your organization provide any of the following services? *Select all that apply*

- ☐ physical health care
- ☐ behavioral health care
- ☐ oral health care
- ☐ public health services
- ☐ substance use disorder treatment
- ☐ food assistance
- ☐ transportation assistance
- ☐ utility assistance
- ☐ housing assistance
- ☐ domestic violence / sexual assault assistance
- ☐ other *Please describe*

3. Please briefly describe your organization’s main activities or programs. *3-4 sentences*

Enter text here

4. Is your organization participating in Accountable Health Communities? *Select one.*

- ☐ currently participating
- ☐ planning to participate in the next 12 months
- ☐ not participating or planning to participate
- ☐ not yet decided whether we will participate
- ☐ I do not know

Comment:

5. **Is your organization involved in any cross-sector health partnerships other than Accountable Health Communities?** “Cross sector health partnerships” are agreements to jointly develop goals, exchange information or resources, or coordinate activities, and involve organizations from more than one sector such as education, housing, or criminal justice. *Select one.*

- ☐ currently participating in other cross-sector health partnerships
- ☐ planning to participate in other cross-sector health partnerships in the next 12 months
- ☐ not participating or planning to participate in other cross-sector health partnerships
- ☐ not yet decided whether we will participate in any other cross-sector health partnerships
- ☐ I do not know

6b. If yes, what other cross-sector partnerships are you participating in or considering participating in?

Name or brief description of cross-sector health partnership

6. **Does your organization collaborate with other organizations who provide the following types of services?** Examples of collaboration include developing shared goals, coordinating activities, or entering agreements to exchange information or share resources. *Select all that apply.*

	Past collaboration	Current collaboration	Future / planned collaboration
Physical health care	☐	☐	☐
Behavioral health care	☐	☐	☐
Oral health care	☐	☐	☐
Public health services	☐	☐	☐
Substance use disorder treatment	☐	☐	☐
Food assistance	☐	☐	☐
Transportation assistance	☐	☐	☐
Utility assistance	☐	☐	☐
Housing assistance	☐	☐	☐
Domestic violence / sexual assault assistance	☐	☐	☐
Other <i>please describe</i>	☐	☐	☐

7. In which of the following counties does your organization work? *Select all that apply.*

Currently work in
the following counties:

- ☐ Crook
- ☐ Curry
- ☐ Deschutes
- ☐ Hood River
- ☐ Jackson
- ☐ Jefferson
- ☐ Josephine
- ☐ Yamhill
- ☐ Wasco

Planning to work in the following
counties in the next 12 months:

- ☐ Crook
- ☐ Curry
- ☐ Deschutes
- ☐ Hood River
- ☐ Jackson
- ☐ Jefferson
- ☐ Josephine
- ☐ Yamhill
- ☐ Wasco

7b. <SKIP LOGIC: for counties marked “Currently work in this county”>

How long has your organization been providing services in these counties?

Please give your best estimate if you do not know the exact answer.

County Name ☐ Less than a year ☐ 1-10 years ☐ More than 10
years ☐ Unknown

<repeat with list of counties>

7c. <SKIP LOGIC: for counties marked “Currently work”>

How many employees of your organization currently work in these counties?

Please give your best estimate if you do not know the exact answer.

County Name ☐ None physically located here ☐ 1-4 staff ☐ 5 or
more staff ☐ Unknown

<repeat with list of counties>

8. What is your organization’s current annual operating budget? *Select one.*

- ☐ Less than \$1,000,000
- ☐ \$1,000,000 - \$5,000,000
- ☐ Greater than \$5,000,000
- ☐ I do not know

Please provide your name and an email address in the event that the researcher needs to follow-up with you. Your contact information is confidential and will not be published or shared. You may decline to provide this information, but it will then be impossible for the researcher to follow-up with you for clarification of information provided.

9. What is your name?

Enter your name here

10. What is your email address?

Enter your email address here

Thank you for responding to this survey. By clicking “Submit” below, your responses will be recorded and submitted.

→ Submit

If you have questions about this survey or research project, please contact:

Shauna Petchel, MPH
Principal Investigator
OHSU-PSU School of Public Health
[redacted]

Sherril Gelmon, DrPH
Co-principal Investigator and Professor
OHSU-PSU School of Public Health
[redacted]

If you have concerns about your rights as a research participant, please contact the Portland State University Office for Research Integrity (ORI) at (503) 725-2227 or 1 (877) 480-4400 or email hsrrc@pdx.edu. You may also access the IRB website at <https://sites.google.com/a/pdx.edu/research/integrity>.

Appendix E: Survey Invitation

TO: <NAME>
From: Shauna Petchel, MPH
Subject: Link to online survey

You are receiving this email because you have expressed interest in participating in research being conducted by Shauna Petchel, a doctoral candidate at the OHSU-PSU School of Public Health. The research consists of surveys and interviews to understand the experiences of organizations engaged in cross-sector partnerships addressing social determinants of health. Your organization was identified because of your involvement in Accountable Health Communities.

This email contains a link to the online survey being conducted as part of this research. The estimated time to complete this survey is 15 minutes. The survey consists of 10 questions (most of which are multiple choice) related to your organization's activities and partnerships. You should not need to collect any records or information before beginning.

Your participation is voluntary. If you consent to participate, please complete the survey at the link below within the next 7 days. If you choose, you may forward this link to another person at your organization to complete the survey. If you forward the link, please ensure you do not submit more than one survey on behalf of your organization. Please do not forward the link outside your organization.

If you need assistance accessing the survey, or need this survey in a different format, please contact Shauna Petchel (the researcher) at [redacted] or at [redacted].

<<Go to Survey>>

Appendix F: Interview Protocol

Interview Introduction

Thank you for speaking with me today. I am a doctoral student conducting this research for my dissertation at the OHSU-PSU School of Public Health. This project is being supervised by Dr. Sherril Gelmon, my dissertation committee chair, and has been approved by PSU's Institutional Review Board. Dr. Bruce Goldberg of ORPRN and the School of Public Health is one of my committee members, but I am not conducting this research on behalf of ORPRN or Accountable Health Communities.

The purpose of this research is to understand the experiences of organizations engaged in Accountable Health Communities and other cross-sector health partnerships that bring together organizations from the health sector and other sectors such as social services or housing. I'm interested in your unique perspective, and there are no right or wrong answers to the questions I'll ask you today.

This interview will last about an hour and will cover ten questions. Since our time is limited, please keep your answers brief, and I will ask you follow-up questions if needed. You may also decline to answer any questions during the interview. With your permission, I will audio-record the interview so that I can later transcribe it for further analysis. Your name, your organization's name, and any personally identifying information will not appear in the transcripts, notes or any reports produced from this research. You will be assigned an identification number in place of your name in the research database, and only I and my supervisor, Dr. Sherril Gelmon, will have access to the raw data.

Before we get started, do you have any questions about the consent form I provided to you? *<answer any questions here and collect signed consent form>*

Do I have your permission to record this interview? *<if yes, turn on recorder>*

Interview Questions

1. First, tell me a bit about yourself. What is your background and how did you come to be working with <organization>? Please answer briefly.
 - i. What drew you to doing this kind of work?
2. How is <organization> involved with the Accountable Health Communities (or AHC) project? Has <organization> taken on new work or activities because of AHC? How did that come about?

- i. Who was involved in planning or deciding to take on that new work, either at <organization> or outside <organization>?
 - ii. What was the decision-making process involved in establishing those new activities?
- 3. Thinking about those activities you just described, what factors are important to consider when <organization> takes on those kinds of new activities? For example, are there particular rules in your industry, or business requirements you need to be mindful of?
 - i. Are there particular people or stakeholders whose views you need to be mindful of, either at <organization> or somewhere else?
- 4. Are there financial or nonfinancial risks for <organization>, or things you worry could not go as planned, when participating in a cross-sector project such as Accountable Health Communities?
 - i. Are there any big “unknowns” or uncertainties you wonder about? If so, what are they?
 - ii. Are there any risks in *declining* to participate?
- 5. Are there potential benefits for <organization> participating in a cross-sector project such as Accountable Health Communities? If so, what kind of benefits? How would you judge whether <organization> is better off because of its involvement with AHC?
 - i. How likely or predictable are those benefits?
 - ii. On what timeline would you expect to see those benefits?

Now I’d like to ask you about the group of organizations participating in the Accountable Health Communities project. Because these questions are about other organizations in the community, I want to reiterate that your answers are confidential, and that you can decline to answer any question.

- 6. What kinds of challenges or problems do you think cross-sector partnerships such as the Accountable Health Communities project are designed to address?
 - i. Why do you think those challenges have not been overcome before now?

7. Are cross-sector partnerships a good approach for overcoming these kinds of challenges? Why or why not?
 - i. Does a cross-sector approach help you overcome challenges that you could not overcome on your own? How?
 - ii. Is there anything in particular about the structure or approach used in cross-sector partnerships that makes them useful for addressing the challenges you described?
8. How easy or difficult do you think it is for organizations to adopt shared goals and strategies in cross-sector projects such as Accountable Health Communities? Do organizations ever find themselves with conflicting goals?
 - i. Has there ever been a time in AHC or other cross-sector partnerships when your goals have been in tension with another organization's goals? If so, how?
 - ii. If you found yourself in that situation, what would you need to consider in deciding how to move forward?
9. Are there certain sectors or organizations that have more influence than others in cross-sector projects such as Accountable Health Communities? If so, how do those differences in influence show up, for example in decision making? What does that look like?
 - i. Is there anyone involved in projects like AHC who *is not* involved in decision making?
 - ii. Is that the right approach to group decision-making? Why or why not?
10. Given your experience so far, how likely is it that <organization> will continue to participate in cross-sector projects such as Accountable Health Communities in the future?
 - i. Is there anything that would make you more or less likely to continue to participate?

Wrap-up

Those are all of the questions I had for you today. Before we conclude, is there anything we have not talked about that you would like me to know about your experience with cross-sector partnerships such as Accountable Health Communities?

Thank you very much for your time today. When this research is completed, I will be happy to provide you a copy of my dissertation or other materials that are produced from the findings if you wish.

If you have any questions for me after today, you can reach me by phone or email.
<share contact info if not already done>

Appendix G: Network Maps

Figure G.1 - Network Map of All Accountable Health Communities Regions (de-identified)

Figure G.2 - Network Map of AHC Region A (de-identified)

Figure G.3 - Network Map of AHC Region B (de-identified)

Figure G.4 - Network Map of AHC Region C (de-identified)

Figure G.5 - Network Map of AHC Region D (de-identified)