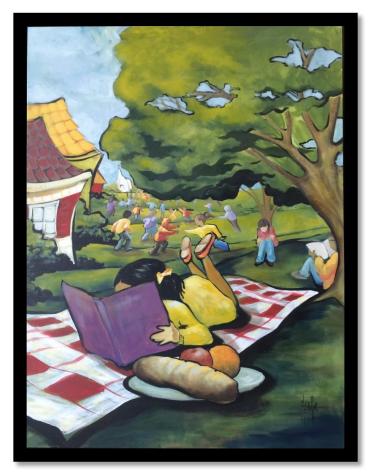BUILDING HEALTHY COMMUNITIES: LEARNING FROM THE PARTNERSHIP FOR A HEALTHY DURHAM

Artist: Eleatta Diver

9/30/2016	**Partnership Frameworks**

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This document provides supplemental information for the study *Building Healthy Communities: Learning from the Partnership for a Healthy Durham*. This supplemental report provides additional details about the data analysis approach used for the study. For a list of all study-related reports see Appendix A.

Partnership Frameworks

As part of our analysis we looked at the way the Partnership for a Healthy Durham is aligned with two conceptual frameworks developed to deepen our understanding of what makes integrated collaborative efforts successful.

Building Healthy Communities (BHC) model

The Building Healthy Communities (BHC) project is part of a larger Family Health International (FHI) Foundation project to build evidence on the efficacy of integrated, multi-sector approaches to public health challenges. The BHC goal is to learn from efforts underway across the United States to improve the health of Americans through community change. The BHC model, depicted at the left, features five goals for achieving healthy communities. It addresses health directly, as well as major determinants of health (education and economic opportunity). At its core is a focus on addressing disparities and health equity through an informed and engaged community population. The primary modes of community-wide change—programs, systems, policy, and infrastructure—are also identified. This model highlights the role and importance of all sectors and factors, including clean and safe environments, economic opportunity, educational attainment, access to quality health care, and healthy living. The following outlines how findings from the study conducted with the Partnership for a Healthy Durham map onto the BHC model.

Five goals for achieving healthy communities

The Partnership for a Healthy Durham focuses its direct work on three of the five goals identified in the BHC model: providing quality, accessible, and cost-effective health care; making healthy living easier; and providing clean and safe environments. There is a keen awareness on the part of the Partnership regarding the importance of the other two goals – creating economic opportunity and improving educational attainment and opportunity – for fostering the Partnership's success. This is most clearly seen in the inclusion of poverty and education as priorities to be incorporated within each of the committees. The Partnership also seeks ways to work with End Poverty Durham (a group of interfaith leaders and community-based organizations working collaboratively to eliminate poverty in Durham) and the Durham Public Schools.

Engaged and informed community

The BHC model places engaged and informed communities at the core of addressing disparities and supporting health equity. When describing the work of the Partnership in interviews and focus groups, community engagement and communication were repeatedly emphasized by leaders and active members. Most often, the conversation centered on the challenges including descriptions of how the Partnership was attempting to address the challenges at multiple levels. Stories of engagement centered on being out in the community, putting on events and activities in neighborhood settings, and reaching out to people individually to help them access programs. Examples include painting sidewalks and putting up signs for Healthy Mile trails in neighborhoods, providing HIV testing services at community events and music venues, following up with individuals to see if they were accessing food subsidy programs, and organizing a celebratory parade for recovering substance users. All such activities require considerable investments of time, energy and resources. Most is leveraged from the organizations in the Partnership; some comes from funding opportunities such as the RWJF Culture of Health Prize, donations from the private sector, and community volunteers.

The following quote illustrates how engaging and informing are interconnected, and the importance of having an iterative process of engagement and communication in place.

> *"So the community has said they want access to healthy foods [and] they want access to physical activity in their neighborhoods, so we're doing little walking trails in people's neighborhoods and stenciling the sidewalks and putting up maps. And then the community has said they want classes, like smoking cessation classes, nutrition classes, cooking classes. [But] we're already providing them, and a lot of the partners that come to the table are already providing these classes, and we just realized it's a communication issue and not linking the people who want them with the classes. And so we're focusing on communicating and figuring out like where these classes have to be… if they should be somewhere else, if that's why people don't know about them, or if we just need to publicize it better." (IDI participant)*

The structure of the Partnership creates challenges for engaging community members on the committees. The history of the HIV committee within the Partnership was a recurrent example of a committee that had a volunteer community member as a co-chair as well as an example of the challenges the Partnership structure presented for engagement. When the Partnership was formed, an existing community-based project called Project Straight Talk became the basis for the HIV committee.

> *"THERE WERE MANY MORE PEOPLE WITH HIV WHO WERE THERE… THERE WERE GRANNIES. THERE WERE WOMEN WHOSE HUSBANDS WERE INFECTED… AND WE LOST THAT [INVOLVEMENT]… I THINK THAT IT WAS HARDER FOR THEM TO HAVE A VOICE BECAUSE WE WERE HAVING TO MAKE THESE FIVE-YEAR PLANS… THEY WANTED TO TELL THEIR STORY, AND THAT PLATFORM HAD KIND OF BEEN LOST FOR THEM." (IDI PARTICIPANT)*

Modes of community-wide change

Programs -- i.e., organized series of activities directed towards the attainment of defined objectives and targets [WHO definition] -- were identified as the primary mode for achieving positive community-wide change. This reflects the day-to-day focus of the work carried out by many Partnership members. Many of the organizations represented within the Partnership are funded to implement programs, and the workplans for the Partnership committees are program-focused. At the same time, the programmatic work often intersects with the other modes of change outlined in the BHC model. For example, the work of the Obesity and Chronic Illness Committee includes developing Healthy Mile trails described above to encourage exercise in neighborhoods (infrastructure) and the Access to Care Committee has held various community meetings and worked with local media to provide information on health care reform (policy).

The Partnership as a whole represents a system-level mode of change in support of achieving a healthy community, and is part of the former state-wide Healthy Carolinians network of partnerships that address health and safety issues at the community level and are aligned with the Healthy North Carolina 2020 health objectives. Because the day-to-day work is programmatic, we found in our interviews and focus groups that most people struggled to describe infrastructure, policy or systems level modes of change resulting from their work. As one of the Partnership leaders we interviewed described, it can be hard for people to see the cumulative impact of change at such broad levels.

> *"...YOU REALLY NEED TO WORK WITH LOTS OF OTHER PARTNERS TO REALLY MAKE A DIFFERENCE...AND IT TAKES A LONG TIME, TOO, LIKE OUR ACTION PLAN IS FOR THREE YEARS BUT FOR THE EDUCATION OR ERADICATING POVERTY [PRIORITIES], THAT'S A GENERATION THING. IT'S TWENTY, THIRTY YEARS. IT'S NOT GOING TO HAPPEN IN THREE YEARS OR EVEN FIVE OR TEN. WE DO HAVE MEMBERS THAT HAVE BEEN INVOLVED FOR A LONG TIME, BUT YOU KNOW, SOMETIMES PEOPLE ARE HERE FOR A YEAR OR TWO AND THEY MAY NOT SEE A LOT OF PROGRESS BECAUSE IT TAKES A LOT TO MOVE THAT NEEDLE." (IDI PARTICIPANT)*

This statement underscores the importance of the Partnership's role in supporting and disseminating empirical evidence on the health of the community. Every three years the county undertakes a Community Health Assessment that informs the health priorities that are the focus of the Partnership's committees. An annual State of the County Health report updates statistics from the most recent Community Health Assessment and reports on progress on the health priorities. What is lacking is a systematic framework for documenting and evaluating the connections between the Partnership's communication, engagement, and programmatic work and the Partnership's goal that "the people of Durham will enjoy good physical, mental, and social health and well-being."

Integrator Model

The concept of an integrator role grew out of the historical development of the Chronic Care Model, with increasing recognition of the importance of "complementary community systems that make healthier choices the default or easier option" (Dietz et al. 2015, p. 1457). Bringing health care delivery systems together with community services to achieve this kind of integration requires "a trusted convener or integrator, who commands mutual respect and shares stakeholder values" (Dietz et al. 2015, p. 1457). As defined by Nemours "An integrator is an entity that serves a convening role and works intentionally and systemically across various sectors to achieve improvement in health and well-being" (*Integrator Role and Functions in Population Health Improvement Initiatives*, 2012). The Partnership for a Healthy Durham explicitly takes on this role and function.

> *"There are many non-profit organizations in Durham County. The Partnership, which is not a non-profit organization and does not compete for funds, occupies a neutral position in this landscape... organizations without an explicit health focus participate in the Partnership, enriching perspectives and opportunities for collaboration...the Partnership was established as a place to meet people, develop relationships, and create effective projects, and it was able to powerfully support collaborative work to improve health in Durham." (From Durham RWJF Roadmaps to Health Prize Essay[1])*

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[1] http://healthydurham.org/cms/wp-content/uploads/2016/03/2013-Roadmaps-to-Health-Prize-essay-II-2013.pdf

The integrator role includes 11 functions (Dietz et al., 2015). In the interviews and focus groups we conducted, six of these roles were explicitly referenced:

- Lead = serve as a trusted and accountable leader
- Engage = engages partners from multiple sectors
- Sustain change = sustains change by impacting policies and practices in collaboration with institutions and community partners at the local, community, and state levels
- Fund change = pursues financial sustainability including opportunities to employ multiple funding streams
- Research = gathers, analyzes, monitors, integrates, learns, and shares data at the individual and population level
- Communicate = develops a system of ongoing and intentional communication with affected sectors, systems, and communities

Other integrator roles were not explicitly described in the interviews and focus groups but are evident to varying degrees when reviewing online documents:

- Facilitate goals = facilitates agreement among multisector stakeholders on shared goals and metrics
- Assess resources = assesses community resources, including workforce capabilities, and work with partners to make appropriate adjustments
- System change = works at the systems level to make policy and practice changes in public and private sectors
- Scale change = conveys what works at the policy/systems practice levels to reach sufficient scale
- Find navigators = identifies and connects with system navigators who help individuals coordinate, access, and manage multiple services and supports

In this section, we summarize our findings on how the Partnership for a Healthy Durham functions as an integrator.

Lead and Engage

Leading and engaging emerged as explicit core functions of the Partnership. IDI and FGD participants described effective leadership within the partnership in terms of collaborative spirit, individual passion, history of community engagement, ability to listen & make people feel welcome, depth of experience, strategic thinking, and ability to see the big picture.

The ability of the Partnership to engage a diverse range of stakeholders was frequently highlighted and attributed as much to a Durham culture of collaboration as to the Partnership itself. *"DURHAM TENDS TO BE DIFFERENT IN THAT PEOPLE TEND TO WANT TO WORK TOGETHER,"* one FGD participant noted, adding *"EVERY ONE OF OUR SITES, EVERY ONE OF OUR PROJECTS IS A COLLABORATION WITH SEVERAL COMMUNITY PARTNERS."* There was awareness of the need to not duplicate or compete with the work of others in Durham, especially with regard to how socioeconomic determinants were addressed. People recognized that well-intended but poorly coordinated efforts to break out of silos can result in

unnecessary duplication of effort or competition for scarce resources. *"THERE'S NO NEED FOR THE PARTNERSHIP TO REPLICATE POVERTY-RELATED ACTIVITIES BECAUSE THERE'S A GROUP IN THE CITY WHO'S SPENDING TIME WITH THAT WHO SHARES SOME COMMON GOALS WITH THE PARTNERSHIP,"* one IDI participant said. Another IDI participant said that *"THE PARTNERSHIP CONSCIOUSLY MADE DECISIONS TO SAY WE'RE GOING TO SUPPORT THE POVERTY REDUCTION INITIATIVES OF OTHER COMMUNITY PARTNERS RATHER THAN TRYING TO CREATE OUR OWN, AND I THINK THOSE ARE GOOD DECISIONS."* Similarly, when issues of concern in other local partnerships intersects with the established work of the Partnership for a Healthy Durham, efforts are made to bring that work together. For example, a group addressing homelessness in Durham considered forming a committee specifically to address issues of access to care among the homeless. A Partnership member who was also a member of this group

> *"...CAME FORWARD AND SAID, LOOK, YOU KNOW, THE PARTNERSHIP FOR A HEALTHY DURHAM ALREADY HAS AN ACCESS TO CARE COMMITTEE. MAYBE WE REALLY SHOULDN'T TRY TO FORM AN ACCESS TO CARE COMMITTEE THAT'S SPECIFICALLY FOCUSED ON THE CARE NEEDS AND ACCESS NEEDS OF HOMELESS PEOPLE BUT, YOU KNOW, COULD WE PERHAPS WORK TOGETHER AND MAKE THIS PART OF THE FOCUS OF THE ACCESS TO CARE COMMITTEE? SO THERE WAS A GENERAL SENSE THAT, YES, THE [GROUP'S] INTEREST IN THE ISSUES OF HEALTH CARE ACCESS AND OTHER ACCESS TO CARE FOR HOMELESS PEOPLE WOULD BE PLACED UNDER THE UMBRELLA OF THE ACCESS TO CARE COMMITTEE OF THE PARTNERSHIP."* (IDI participant)

Engagement challenges within and across sectors in the county were noted by some. Bringing the private sector to the table was also noted as something that happens occasionally (e.g., working with groceries or gas stations to offer healthy food options) but not easily. With regard to poverty and education, one IDI participant noted that *"YOU REALLY NEED TO WORK WITH LOTS OF OTHER PARTNERS TO REALLY MAKE A DIFFERENCE."* An FGD participant said*, "WE NEED MORE PEOPLE AT THE TABLE, BECAUSE LIKE A LOT OF US ARE JUST PUBLIC HEALTH PEOPLE, AND THAT'S NOT ENCOMPASSING ALL OF DURHAM."* Not everyone viewed the engagement "glass" as mostly empty, however. As another FGD participant noted, *"HALF OF THE MEMBERSHIP IS HEALTH DEPARTMENT, BUT IT'S NICE THAT IT IS ONLY HALF BECAUSE THERE ARE OTHER COMMUNITY MEMBERS AND PEOPLE FROM DIFFERENT COMMUNITY GROUPS AND ORGANIZATIONS WHO COME. IT'S A GREAT WAY TO MAKE CONNECTIONS."*

The connection between leading and engaging emerged most explicitly when people talked about grassroots community involvement. One IDI participant noted that *"WHEN YOU HAVE PEOPLE COMING TOGETHER FROM ALL THESE ORGANIZATIONS FROM DIFFERENT PARTS AND YOU'RE COMING TOGETHER TO TALK ABOUT A COMMUNITY THAT YOU'RE NOT A PART OF IN MOST CASES, THE COMMUNITY ISN'T REALLY GONNA HEAR YOU."* The challenge of bridging this gap was noted in every interview and focus group. Some challenges were seen as specific to stigmatized issues such as HIV/STI and mental health. One IDI participant noted that other issues, such as violence, are cyclical and potentially polarizing if not handled with sensitivity to what drives those cycles.

Sustain, Scale, Fund and work to bring about System-level Change
System-level change is fundamental to the mission of the Partnership. Examples include:

- Access to Care committee tracks the implications of national and state level health system changes for Durham residents, and proactively seeks to address barriers faced by residents in accessing the services they need.
- Communications committee is providing a forum for discussing and addressing complex issues related to developing a better coordinated referral resource in Durham that addresses limitations in current systems including Network of Care, United Way 211 and Community Oriented Approach to Coordinated Health Care (COACH).
- OCI committee was engaged in advocacy along with community members in a successful reconfiguration of a major street (a section of the Hwy 15-501 corridor) to include bike lanes.
- The Partnership created action plans to reach out to the Durham business community to offer the services of community health experts to assist businesses in implementing strategies that will make happier and healthier employees.
- The HIV/STI committee, through its Durham Knows *RWJF Culture of Health Prize* mini-grant-funded project, has raised awareness of PrEP with healthcare providers and is advocating for HIV testing as a routine part of medical care in Durham.

The historical context within which the Partnership for a Healthy Durham was formed provides a complex example of funding and sustainability dynamics. The Partnership emerged from a convergence of federal (HHS), state (Healthy Carolinians), county and city (results-based accountability) programs in 2004. At that time, there were county-based mini grants that groups like the Partnership could apply for. But, *"those mini grants went away"* which initially *was "a driver for us to begin seeking outside funding."* Over time, the absence of funding to support Partnership activities became the status quo and, as one IDI participant described, *"there's very little incentive for you to go do this now because your mindset is thinking we're gonna sort of work without needing money."*

Structural barriers to funding and sustaining change were frequently noted, often reflecting historical trends that were beyond the direct influence of Partnership leaders and members. One example centered on the loss of funding to support a successful community-based program of activities for World AIDS Day. The HIV/STI committee led planning for the annual event at the Hayti Heritage Center, a cultural enrichment and arts education facility in downtown Durham. The event included multicultural performances, tee shirts, food, certificates recognizing individual and group contributions, onsite HIV testing and counseling, and tabling by organizations working in Durham. *"It used to be funded from drug company money entirely"* explained one IDI participant, but the Partnership is not structured to directly manage funds and the health department is legally constrained from taking on this role. For a number of years, the funds were managed through Duke University, but a change in rules meant that the University began to charge overhead to manage the funds such that *"now Duke takes twenty-five percent off the top of any of those benevolent funds that come in."* Similar challenges were met when trying to funnel the money through state-run schools, and none of the smaller NGO's affiliated with the HIV committee had the capacity to

manage the funds. As one IDI participant said, *"SOME OF OUR ORGANIZATIONS AREN'T EVEN 501(3)(C), SO THERE'S NO WAY THAT THEY'RE GOING TO GET IT. AND SO IT JUST BECAME IMPOSSIBLE TO DO."* The funding dilemma has been met with creativity and strategic refocusing on the part of the HIV/STI Committee in order to sustain this important community-based event. Last year the Partnership's World AIDS Day event was held at the LGBTQ Center of Durham, with HIV testing provided by Triangle Empowerment, another LGBTQ-focused NGO and refreshments provided by 2BeatHIV, a UNC-CH project focused on engaging communities to find a cure for HIV.

The success of a Partnership-led broad integrated approach to promoting community wellness in Durham has been noted elsewhere (Svara, 2014). Broad engagement at times creates challenges for focusing and sustaining effort. One IDI participant noted that in the past, it was passion that brought community leaders to the table and this could be lost when leadership came primarily from organizational representatives. *"THERE WERE MORE COMMITTED PEOPLE AT THE TABLE THAT SEEMED TO BE THERE OUT OF PASSION AND GRASSROOTS CONCERN ABOUT THE COMMUNITY,"* this IDI participant said, *"RATHER THAN THEIR OWN PERSPECTIVE THAT THEY BROUGHT IN TERMS OF THEIR AGENCY [ORGANIZATION] OR THEIR AGENCY SAYING, 'YOU WILL BE AT THIS MEETING.'"* When community-grounded, passion was viewed as an important element of the Partnership's success. However, it was also noted that there can be a misfit when passion is combined with an essentially outsider role, driven by personal or institutional priorities rather than those grounded within the broader Durham community. One IDI participant described how a particular committee was instituted because *"THERE WAS A GRADUATE STUDENT WHO STARTED COMING AND REALLY WAS INTO"* that particular issue but *"THEN SHE GRADUATED AND THERE WAS NO ONE TO LEAD THAT GROUP ANYMORE. SO IT'S KIND OF AN ISSUE IF PEOPLE COME AND GO."*

An important piece of the sustainability challenge is trust. Trust keeps people at the table and willing to continue working on a problem even when it is unclear where the resources will come from to support the work. The willingness of the Durham County Department of Public Health to provide basic resources generates a baseline of trust. *"I THINK THE STRENGTHS OF THE STRUCTURE IS THE BACKBONE OF THE HEALTH DEPARTMENT,"* said one IDI participant. *"WHAT THE HEALTH DEPARTMENT BRINGS IN TERMS OF STRUCTURE, OVERSIGHT, FISCAL RESPONSIBILITY, AND THE ABILITY TO OBTAIN GRANT FUNDS, AND PROVIDING THE OVERALL STRUCTURE FOR THE SUB-COMMITTEES I THINK IS AN ABSOLUTE STRENGTH."* Another IDI participant described the Partnership as *"A PLACE FOR PEOPLE TO HAVE CONVERSATIONS"* about funding opportunities, noting *"WE ALREADY HAVE THOSE RELATIONSHIPS BUILT AND THE TRUST IS ALREADY THERE, SO WE'RE A LITTLE BIT MORE WILLING TO SAY, OKAY, I CAN DONATE [RESOURCES TO] THIS BECAUSE WE KNOW THAT OTHER PERSON IS GONNA SHOW UP AND DONATE SOMETHING ELSE."* Some people cited the historical contributions of particular committees as evidence that they can be relied upon to work with effective partners who *"WILL WORK VERY HARD TO MAKE SURE THAT IT'S SUSTAINABLE, LIKE THAT THERE'S A PLAN IN PLACE FOR FUNDING BEYOND THIS INITIAL SEED GRANT.(FGD PARTICIPANT)* The close partnership between the Access to Care Committee and Project Access in Durham was one such example. Another example centered on the Obesity and Chronic Illness Committee's efforts *"NOT TO OWN ALL THE HEALTHY MILE TRAILS"* that they have established to encourage exercise in Durham neighborhoods. *"THEY'RE TRYING TO FIGURE OUT HOW TO PASS THESE ALONG TO COMMUNITY GROUPS,"* one

FGD participant said, *"BECAUSE IT TAKES UPKEEP AND PEOPLE HAVE TO KNOW HOW TO KEEP THEM SAFE. IT'S ONE OF THOSE COLLABORATIVE PROCESSES WHERE WE AS OCI ARE TRYING TO SPIN THAT OFF TO OTHER GROUPS."*

Research

The research function is a core part of the Partnership's integrator role. The Partnership is responsible for conducting the state-mandated Community Health Assessment at least once every four years and for publishing the state-mandated annual State of the County Health reports in interim years. The Durham County assessment occurs every three years, which aligns the work with the federally mandated community health assessments required of hospital systems under the Federal Patient Protection and Affordable Care Act. The most recent assessment was financially supported in part by the Duke University Division of Community Health, who also provided a part-time staff person to assist with the health assessment. This kind of collaboration thus serves to minimize duplication of effort and burden on community residents to meet multiple reporting requirements among the partners.

The Partnership maintains online data resources including the county health reports, community health assessments, YBRS detailed data reports for Durham, links to North Carolina state reports and data, and a variety of independent health-related reports and online resources such as the RWJF County Health Rankings, the USDA Food Access Research Atlas, and a series of reports on substance use and abuse in Durham County compiled by the Duke Center for Child and Family Policy.

The Partnership's research function goes beyond data collection, analysis and dissemination to include how findings are interpreted and used to guide its work. The HIV/STI committee is an example of how Partnership members helped contextualize the community feedback and data from the 2014 health assessment. At that time, HIV was not ranked as a health priority in the survey or in the community listening sessions. Based on those findings, the Partnership leadership was initially inclined to cut the HIV committee, but committee members pushed back. *"LET'S GO BACK TO STATISTICS HERE,"* one IDI participant reported saying. *"WHAT RANKING DOES DURHAM COUNTY HAVE [IN THE STATE FOR NEW HIV INFECTIONS]? FOURTH. AND I SAID, WHAT IS IMPORTANT HERE?"* Another IDI participant noted that *"HIV'S NOT GONNA BE SOMETHING THAT PEOPLE ARE GONNA MENTION, EVEN IF THEIR SON HAS HIV OR EVEN IF THEIR HUSBAND DIED OF HIV...SO IT'S [A CHALLENGE] TO GET AT SOME OF THOSE STIGMAS. AN OBESE PERSON IS NOT LIKELY TO SAY, OH, I REALLY THINK OBESITY AND GETTING A HANDLE ON MY OBESITY IS A PROBLEM. SO YOU WANT TO TEASE THOSE QUESTIONS OUT TO THE PARTNERSHIP AS A WHOLE SO THAT...WE'RE NOT LEAVING SOME OF THE PEOPLE BEHIND."*

In another example from the Mental Health & Substance Use committee it was noted that a key organization kept *"A DATABASE OF ALL THE PROVIDERS IN DURHAM COUNTY, AND OVER THE SUMMER I DECIDED I WOULD VERIFY WHETHER THESE PROVIDERS ARE ACTIVE, AND IF THEY'RE ACTIVE, HOW FAST AND WELL DO THEY RESPOND TO THE NEEDS OF THE COMMUNITY. I HAD AN INTERN...SPEND TWO WEEKS CONTACTING ALL 109 PROVIDERS. AND WE LEARNED QUITE A BIT, AND I'VE NOW SENT THAT OUT TO THE WHOLE COMMITTEE BECAUSE*

IT'S RATHER TELLING…SOME ARE NOT PROVIDING THE SERVICES THEY SAY THEY ARE. IN SOME CASES IT TOOK US FIVE DIFFERENT PEOPLE, AND FIVE DIFFERENT PHONE CALLS IN ONE CASE, TO GET TO THE RIGHT PERSON. SO IF YOU'RE A FAMILY IN CRISIS, THAT'S A PROBLEM…AND SO WE GOT LOTS OF REALLY GREAT DATA ABOUT THAT, AND A LOT NEEDS TO CHANGE ABOUT THAT, AND HOPEFULLY IT WILL. SO I'D LIKE TO SEE OUR COMMITTEE PUSH A LITTLE BIT ON THAT, TOO." (IDI PARTICIPANT)

Communicate

The communication function of the Partnership is recognized by all as both critical and challenging due to the large number of organizations and individuals who are members and the range of activities the Partnership is engaged with. Partnership members and others in Durham who may be interested in the Partnership's work have a wide range of preferred communication styles and varying levels of comfort with different technologies and platforms. For example, it has been challenging to find an email system that is easy to use for monthly updates to full membership but also supports tracking members for each committee and sharing email addresses with co-chairs. Information overload is also a challenge. As one FGD participant said, *"I CAN'T LOOK AT [THE EMAILS] REALLY QUICKLY AND KNOW WHAT SORT OF ACTION THEY'RE LOOKING FOR SO THEN I JUST… LOOK AT IT AND DELETE."* Another FGD participant talked about how *"WE EACH HAVE OUR OWN LIKE INTERNAL RESOURCE GUIDES. AND THEY'RE LIKE OLD-SCHOOL PDF…IF IT WAS ON A LIVE DOCUMENT ONLINE, THEN WE COULD SEND ALERTS AND STUFF."*

Limited dedicated staff support means that decisions about how communication is coordinated must be strategic. Systems need to be sustainable with limited technical expertise in a dynamic environment where resources, staff, leadership and membership may change substantially in any given 3-year planning cycle. As one FGD participant said, *"IT'S SUPER FRAGMENTED, I THINK, BECAUSE IT'S ALSO NOT REALLY A PART OF ANY OF OUR JOBS."*

Internally, the Partnership has nonetheless established a solid communications platform and is actively pursuing ways to make it better. The basics include quarterly full membership meetings, monthly meetings of the committee co-chairs and of each committee, and a monthly email to all members that includes organizational news supplied by Partnership members. In the past year a Communications Committee was established that includes experts from around the city of Durham. The full time coordinator maintains the Partnership meeting calendar and prompts co-chairs to send out meeting agendas, minutes and other critical information. The agenda and minutes follow a standard table format for all Partnership meetings that includes a row for each agenda item, timeframe, names of presenters and discussion leads, a synopsis of information covered/provided/discussed, any recommendations from the group, and, as appropriate, agreed-on action steps to be taken. Minutes are reviewed and approved at the next subsequent meeting, publically posted to the appropriate committee page on the Partnership website, and shared with committee members via email. Three-year workplans for the committees are also posted, along with reports or links to other materials that are relevant to the committees' work.

> *"I GOT EXPOSED TO PEOPLE IN THE COMMUNITY THAT WERE DOING A LOT OF THINGS THAT I NEVER WOULD HAVE KNOWN ABOUT. I NEVER WOULD HAVE COME ACROSS SOME OF THESE PEOPLE WITHOUT BEING INVOLVED IN THE PARTNERSHIP." (IDI PARTICIPANT)*

> *"I THINK IT'S TRUE ACROSS THE BOARD, BUT CERTAINLY IN DURHAM, WHEN PEOPLE COME TOGETHER, WE CREATE RELATIONSHIPS AND WE GET TO KNOW WHO THE PARTNERS ARE SO THAT WHEN THERE ARE OPPORTUNITIES TO COLLABORATE … THERE ARE NETWORKS OF PEOPLE THAT CAN COMMUNICATE BACK TO SPECIFIC SECTORS OF THE COMMUNITY." (IDI PARTICIPANT)*

> *"I FEEL LIKE THIS COMMITTEE IS RESOURCEFUL FOR ME AND PROVIDES INFORMATION TO ME, ALTHOUGH I'M NOT PHYSICALLY AT THE TABLE EVERY MEETING." (FGD PARTICIPANT)*

Facilitate goals, assess resources and find navigators

The following examples exemplify the Partnership's ability to facilitate goals, assess resources and find navigators as part of its integrator role in Durham.

- The previously noted work by the Communications Committee to address limitations in existing referral resources in Durham. This work has included a review of the current resources in order to identify an optimal collaboration for the Partnership, exploration of potential funding, and consideration of how to make the resource most useful, e.g., website, 24-hour hotline, radius of services listed, and which audience (user-base) to target. The Committee has been developing a phased plan that began with surveying providers and the general public.

- The Access to Care committee keeps itself updated on the impact of ACA and Medicaid implementation on the ability of Durham residents to access healthcare. For example, at the October 2015 committee meeting, it was noted that in Durham County, approximately 2500 individuals need to be recertified for Medicaid each month but information at that time indicated that the Department of Social Services (DSS) only had capacity to recertify 1000 monthly. The anticipated result was a large number of recipients losing benefits each month, including children, and an observed increase in the numbers of children going to the ER for care due to loss in benefits.

- The OCI committee responded to community assessments indicating the city of Durham had an inadequate number of pedestrian walkways and cycle paths by working with multiple organizations to build new bike lanes, bike racks, and sidewalks; to extend the American Tobacco Trail; and to create "Healthy Mile Trail" markers on neighborhood sidewalks.

- The Communications Committee work, described above, is a recent and ongoing effort to assess and improve referral resources in Durham.

- In preparation for ACA open season, the Access to Care Committee October 2015 meeting included updates on navigation support including which organizations, when and where support would be provided, and who was eligible to access support.

Additional findings from this study can be found in a separate report (see Appendix A).

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SUPPLEMENTAL REPORT – REFERENCES

APPENDICES

Appendix A: List of Study-Related Reports

Listed below are study-related reports provided to the Partnership for a Healthy Durham by FHI 360 members of the study team. These reports include a main study report along with four supplemental reports containing expanded details on study methods, the history of the Partnership, descriptions and accomplishments of the Robert Wood Johnson Foundation (RWJF) Culture of Health Prize mini-grants, and additional study findings (i.e., analysis of conceptual frameworks).

1. Building Healthy Communities: Learning from the Partnership for a Healthy Durham

2. Building Healthy Communities: Learning from the Partnership for a Healthy Durham – Expanded Study Methods

3. Building Healthy Communities: Learning from the Partnership for a Healthy Durham – Partnership History

4. Building Healthy Communities: Learning from the Partnership for a Healthy Durham – RWJF mini-grant descriptions and accomplishments

5. Building Healthy Communities: Learning from the Partnership for a Healthy Durham – Partnership Framework