Building Community-Centered Health

Emerging Lessons from Clinical-Community Partnerships in North Carolina

April 2022

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Cover photo credits, right to left: Melissa Lyttle for Politico; Collaborative Cottage Grove Facebook; Healthier Highland Facebook

Executive Summary

"[Our Community-Centered Health partnership] is some of the most meaningful work, and when you're able to look back and just smile on the inside, that brings so much joy."

- Community-Centered Health partner

The Community-Centered Health approach of the Blue Cross and Blue Shield of North Carolina Foundation (the Foundation) addresses root causes of inequitable health by investing in diverse multi-sector partnerships in nine North Carolina communities that amplify community voice in setting local health priorities. Starting in 2015, the Foundation supported its first cohort of three Community-Centered Health grantees (referred to as "Cohort 1") to test and implement partnerships in the cities of Greensboro, Gastonia, and Asheville. Within each community, partnerships received multi-year grant funding along with non-monetary technical assistance, training, coaching, and convening support. Each partnership determined which community needs to address, and chose its own path to achieve greater health equity by focusing on clinical shifts in health care practices that look beyond the walls of health care facilities. By addressing upstream policy, systems, and environmental factors that influence health equity, these communities are addressing the root causes of their most pressing health issues.

The Foundation partnered with Engage R+D to conduct a retrospective evaluation of Cohort 1 partnerships. The evaluation examined early progress and enduring outcomes. The evaluation also revealed lessons about supporting equitable community-driven change. The three partnerships yielding these findings are based in communities experiencing long-standing inequitable conditions. A brief description of the work of each of these partnerships and their partnership structure follows below.

Collaborative Cottage Grove	Healthier Highland	Mothering Asheville
Where: Greensboro, NC	**Where:** Gastonia, NC	**Where:** Asheville, NC
Promoting equitable community development in Cottage Grove to reduce housing-related asthma burden, and improve healthy food access and community environment for all residents.	Building a culture of community-engaged healthy eating and active living in the Highland neighborhood of Gastonia.	Eliminating disparities in infant mortality and improving pregnancy and birth outcomes for African American[1] women and babies in Buncombe County.

Partnership Structure: Each Community-Centered Health partnership typically includes:

- A range of nonprofit organizations addressing health, advocacy, legal services, and social justice, among other areas of expertise;
- Health care clinics, hospitals, and health care networks;
- Leaders and representatives from city government and county agencies;
- Neighborhood associations;
- Faith-based organizations; and
- Educational institutions.

[1] To honor the language and voice of the Community-Centered Health partners, this report uses both African American and Black to refer to the communities and individuals that partners serve.

Evaluation Methods

The evaluation relied upon several methods, including interviews with Cohort 1 grantees, partners, and technical assistance providers; interviews with Foundation staff and other funders and researchers involved in similar community-driven initiatives; and a review of initiative-related documents, as well as secondary population-level data.

The evaluation centers **equitable evaluation principles**[2] in multiple ways. First and foremost, the evaluation team acknowledges that this evaluation is in service of health and racial equity in North Carolina communities. We have worked to build participant ownership with grantees, incorporate their most pressing questions into our evaluative work, and to ensure that the evaluation findings accurately capture and align with the experiences of their unique communities.

This report and the Community-Centered Health Impact Framework that we present intentionally seek to explain the contextual factors that have contributed to present-day health inequities within these communities. By focusing on this historical and structural context, the evaluation is designed to shine a light on the underlying structures and systems that perpetuate health inequities.

Findings from Early Implementation

From the early days of Cohort 1 and throughout the Community-Centered Health initiative, the partnerships engaged in ongoing development of their collaborative capacities. Community-Centered Health partnerships not only required established organizations to work together, but also elevated community residents as leading voices in each partnership's priorities and strategies. The evaluation documents how partners' perspectives on community engagement changed over time. A specific impact of this work is that community engagement evolved substantially. Early on, organizations were more likely to focus on *informing* community residents, but they later evolved to *consulting and collaborating* with them, and ultimately to *deferring* to them as the leaders in Community-Centered Health partnership decision-making.[3]

The evaluation found that common values and practices provide a foundation for achieving successful Community-Centered Health partnerships. A number of **key ingredients of effective clinical-community partnerships** emerged from evaluation interviews and discussions. The following are examples of central components that Cohort 1 grantees and partners highlighted:

- **Addressing structural racism.** The work of addressing structural racism is not easy. Action often requires collaborative partnerships to generate buy-in across a range of diverse partners—some of whom may not believe that structural racism is an issue within their community. Progress in this area requires the commitment of partnerships to a shared vision of examining and pushing back against racist systems, and a range of strategies that includes the key ingredients listed below.
- **Cross-sector commitment to a shared vision.** Each partner must come to the table ready to engage in complex work toward a common goal.
- **Valuing community.** To center community, the partnership must demonstrate that it values lived experience and recognizes community members as experts on what solutions are needed. Cohort 1 partnerships integrated local voices at the table and actively solicited community input to inform partnership actions.
- **Building trust through action over time.** A successful partnership embraces an understanding that developing authentic, trusting relationships takes time and requires actions that substantiate words.
- **Realistic expectations.** Making progress on community-wide cross-sector work is a demanding endeavor with countless small steps and regrouping after missteps or setbacks. Viewing these challenges as opportunities to

[2] Adapted from the Equitable Evaluation Framework: https://www.equitableeval.org/ee-framework.
[3] These findings drew upon a framework for community engagement developed by the Movement Strategy Center. See: "The Spectrum of Community Engagement to Ownership." Accessed December 7, 2021.

learn and build resilience ultimately makes the partnership more effective.

- **Data sharing agreements.** Funders and researchers outside of the Community-Centered Health initiative agreed that data sharing was an essential, and often challenging, component that needed attention from the start of a partnership.

Progress Toward Goals and Outcomes

Community-Centered Health partnerships demonstrate how collaborative, community-driven efforts can build on a foundation of shared values and practices, and work toward community transformation. During the early planning phases of their work, Cohort 1 grantees established the initial structure of their partnerships. They also coordinated with their partners to identify core focus areas, such as community engagement, partnership development, and organizational culture change. During the later stages of implementation, Cohort 1 grantees further refined and clarified data-driven goals reflective of their communities' unique health needs.[4] Each Cohort 1 partnership has made progress toward goals of increasing community engagement and leadership capacity, as well as shifting mindsets and approaches of clinical and government partners. They have also demonstrated how community-based collaboratives can achieve visible and durable change in policy, systems, and environments, as well as in health outcomes, summarized below.

Select Examples of Cohort 1 Progress Toward Community-Centered Health Goals and Outcomes

Area of Progress	Collaborative Cottage Grove	Healthier Highland	Mothering Asheville
Community engagement and leadership capacity	• Clinical-community integration has led institutions to seek community members' knowledge.	• Community members are now change makers and hold decision-making power with government and clinical partners actively listening to and engaging them.	• Community leaders established a needed doula service "for women of color, by women of color."
Shifting mindsets and approaches of clinical and government partners	• The partnership has catalyzed tangible improvements to health access by linking residents to health care and bringing other needed resources into the community.	• The partnership prompted a clinical partner to develop a robust community health worker program that employs local residents.	• The partnership is putting community voice and interests first to address the racial inequities that impact health outcomes for African American women and children.
Upstream changes in policy, systems, and environment	• The partnership successfully remediated close to 200 units of housing, improving conditions for people with asthma.	• Key partners recognize their capacity to improve upstream health factors, such as a health care provider now operating a food enterprise and working on affordable housing.	• The partnership has achieved changes in policy and services that support equity, including greater access to legal services for residents, culturally appropriate care, and health system policies that explicitly recognize racism.
Health outcomes	• Partners have seen decreased emergency department use and increased access to health screenings.	• The partnership saw promising clinical indicators of diabetes and cardiovascular health prior to COVID-19.	• The partnership has made strides in providing access to doula care and improving infant and maternal outcomes for Black women.

[4] The Blue Cross and Blue Shield of North Carolina Foundation. October 2015. Moving Upstream: Clinical-Community Partnership to Improve Population Health.

The Community-Centered Health Cohort 1 partnerships have also had **ripple effects**, with influence spreading beyond their original goals. For instance:

- **Community-Centered Health ideas and practices are spreading to nearby communities.** In one community, for example, a clinical partner has applied successful strategies from Community-Centered Health to other locations where they work. In another, neighboring communities have asked for similar improvements as those that were sparked by the Community-Centered Health partnership's work. Participants of the Community-Centered Health partnership encouraged outside communities looking to adopt similar approaches to plan for the level of work and dedication required to successfully drive community-led change.
- **Community-Centered Health partnerships offer tangible examples of how this work can have ripple effects.** In one community, the partnership successfully launched a local food enterprise and market dedicated to providing healthy, affordable food. An unexpected bonus of this endeavor has been that it attracts people from outside the community who may hold misconceptions to learn about and improve their impression of the neighborhood.
- **Across all partnerships, partners have expanded their capacities and are garnering attention and funding from state and national sources.** Reaching beyond their Community-Centered Health goals, the Cohort 1 partnerships have made connections with regional, state, and national organizations and agencies that are bringing in funded efforts to address community priorities like housing and environmental remediation. Grantees reflected that the Foundation helped them to achieved some of this broader recognition by providing financial support for partnership members to attend and present at professional conferences. All three partnerships have also gained attention and coverage from local, state, and national media.

The partnerships encountered **barriers to implementation,** including resistance by some partners to embrace community-led decision making, and challenges with the logistics and leadership required to coordinate multiple partners around work toward shared goals. In addition, limited data sharing by clinical partners, in part due to policies around patient privacy, hampered some efforts to track progress on addressing disparities in health outcomes.

The Cohort 1 experience also shows how the **broader political and social context** affects the ability of a clinical-community partnership to thrive. The partnerships' achievements, despite structural and policy barriers, demonstrate an ability and growing adeptness to work around difficulties. In addition, the broader context includes community strengths and evolving demographics that reinforce the progress of Community-Centered Health, as shown below.

Summary of Broader Contextual Factors

Contextual Factor	Effects on Partnerships
Structural and systemic barriers	• **Legacies of racism, inequity, and corruption have contributed to community mistrust and underscore the need for community-centered work.** In all three partnerships, a deep history of racism is a clear contributor to existing disparities in economic and health outcomes. In some cases, experiences with corrupt officials have further undermined community trust. • **Entrenched mindsets among some elected officials present barriers to rethinking power dynamics and improving equity.** Resistance by decision makers at local or county levels has impeded progress of equity-focused work and a shift toward community-centered approaches.
Local and state policy context	• **Longstanding neglect by government and developers means residents have unequal access to resources and services.** Marginalized communities do not have access to the same level of basic resources—such as businesses like grocery stores and health care facilities; road maintenance; and funding—as in other parts of the city. In addition, the state's decision not to expand Medicaid disproportionately limits low-income residents' access to health care.
Community strengths and evolving environment	• **Resilience and determination counteract challenges.** Partners across communities commented on residents' and local organizations' inspiring persistence and commitment to collaborative action to make progress in a challenging context.

Contextual Factor	Effects on Partnerships
	• **Demographic shifts can provide impetus and opportunity for change.** Over time, the Cohort 1 communities have become more demographically diverse, which is lifting new community priorities and shifting representation among decision makers. • **Developing collaborative relationships with willing government partners expands opportunities for communities to influence decisions.** As mentioned above, partnerships have faced resistance to their work from some elected officials. However, all three Cohort 1 partnerships have also been successful in actively engaging other local and regional government leaders, garnering support for their efforts and influential voices among decision makers.

What We Can Learn from Community-Centered Health

The Cohort 1 experience with Community-Centered Health shows that **building the power of community members and cultivating community-led decisions can transform the relationship between institutions and the communities they serve.** The partnerships' experience also reveals important lessons for funders and community partners about how to achieve this success, offered here in brief:

- **Lesson 1: Understand and intentionally respond to the influence of historic factors and broader context, being explicit about addressing structural racism.** Context matters when implementing community-driven initiatives that explicitly focus on long-term policy, systems, and environmental change because the status quo is a product of that context. The Community-Centered Health experience affirms that acknowledging systemic racism is a necessary first step to effectively build trust and address upstream health factors.
- **Lesson 2: Ensure that partnerships are committed to building trust and equity with community members and valuing the experience of residents.** Partnerships form around shared goals, but each partner's idea of roles and responsibilities may differ. For cross-sector partnerships that center community to be most effective, partners must be prepared to move from practices of informing or consulting with community residents to collaborating and deferring to residents to drive solutions.
- **Lesson 3: Take the time to develop strong partnerships and build necessary infrastructure, which are critical to long-term and sustainable change**. Partnerships need years to solidify and build their capacity as a collaborative body before they can pursue fundraising beyond an initial grant source. In addition to supporting years-long partnership development, funders and partners also need to provide non-monetary supports and think openly about ways to measure success.
- **Lesson 4: Embrace flexibility to address emergent needs in uncertain times and set realistic expectations while continuing to track progress toward long-term goals.** Funder flexibility is important in addressing needs and issues that inevitably arise during a multi-year effort. The COVID-19 pandemic and concurrent widespread attention to racial equity spurred many Community-Centered Health partner organizations to commit more vocally to addressing racism as a public health issue. The Foundation in turn listened and responded by bringing an interest in discovery, rather than predetermined solutions, and providing flexibility of funding and grant activities in the face of shifting conditions.
- **Lesson 5: Scale or sustain community-driven initiatives with investment from multiple sources.** Plan for diverse multi-year funding to support scaling and sustainability once initial implementation and partnership development are underway. Once partnerships are established, cross-sector collaborations that include government and other institutions are helpful in leveraging funding for partners to access and influence. The original funder can support such avenues by articulating funding diversification as a goal and providing capacity-building training.

In this time of political divisiveness amid monumental global challenges, the Community-Centered Health initiative, with its focus on local collaborative efforts led by the community, offers hope and provides meaningful lessons and examples for achieving positive, informed change.

1 Introduction

A wide range of factors influence our health and well-being, including the social, environmental, structural, and economic conditions where we live and work. These contextual factors—or social determinants of health—have a fundamental impact on health and health inequities. Beyond our individual choices, these factors affect, for example, who is subject to racism and discrimination; who has access to safe housing and neighborhoods; and who has access to clean air and water, secure jobs, and nutritious foods, among other essentials.[5] The Blue Cross and Blue Shield of North Carolina Foundation takes a broad view of supporting health, including addressing root causes of inequitable health outcomes.

Its **Community-Centered Health** approach invests in diverse multi-sector partnerships in select North Carolina communities to focus on improving social determinants of health. Each partnership determines which community needs to address and chooses its own path to achieve greater health equity. Hope, and the fundamental belief that active, engaged communities can realize their goals for healthier, more equitable environments, has been central to Community-Centered Health since its inception. This theme of hope is particularly relevant at the time of this report's writing, with a global pandemic impacting the health and well-being of countless communities. The Community-Centered Health initiative's focus on uplifting community needs and addressing them with community leadership provides evidence of a path forward and a brighter future.

About the Community-Centered Health Evaluation

In February 2020, the Blue Cross and Blue Shield of North Carolina Foundation (the Foundation) partnered with Engage R+D to document the progress and outcomes of its Community-Centered Health investments and inform learning and adaptation. The Foundation initially invested in a cohort of three Community-Centered Health partnerships in different cities across the state in 2015. This group of grantees comprises "Cohort 1" and additional detail on their selection and partnership structure is covered in Chapter 2 of this report.

In partnership with the Foundation, the evaluation team determined that a retrospective approach to documenting grantees' progress would allow for a more holistic understanding of the work. This approach provided an opportunity to explore *what* the partnerships have accomplished, *how* they have made progress, and *which* elements of the approach have been effective. Looking across the partnerships, we identify over-arching successes and challenges and elevate lessons learned that are applicable to the broader field. This retrospective report on Cohort 1 partnerships is one product of the evaluation and learning process.

[5] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Guiding Evaluation Principles

Engage R+D is committed to embedding **Equitable Evaluation** in its work by following these guiding principles: [a]

- Build participant ownership
- Address questions relevant to Community-Centered Health communities
- Embrace multiple realities and truths about how the work is unfolding
- Explore the impact of a Community-Centered Health approach on drivers of health inequities
- Recognize our own biases

[a] Adapted from the Equitable Evaluation Framework: https://www.equitableeval.org/ee-framework.

About this Report

This report is based on findings from Engage R+D's retrospective evaluation of Cohort 1, which seeks to document successes, challenges, and outcomes of the Community-Centered Health Cohort 1 partnerships, and reflect on how these experiences can inform future work (Exhibit 1).

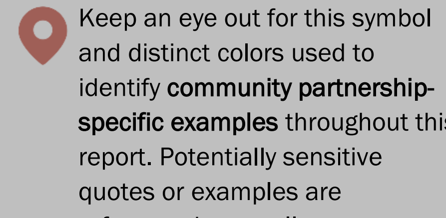
Exhibit 1. Summary of Cohort 1 Evaluation Questions

Area of Interest	Evaluation Questions
Contributing factors	• To what extent have the partnerships leveraged public policy, systems, and environmental changes to produce lasting change? What are the enabling and constraining factors—both internal and external to the initiative that help or hinder their ability to do this? • How have COVID-19 and the racial justice movements impacted the work of the Foundation, the partnerships, and their communities? Specifically, how did this context facilitate and/or hinder their work around racial equity and power-building?
Lessons & implications	• What lessons from the experiences of the Community-Centered Health partnerships can help to strengthen: a) future Community-Centered Health work; b) other Foundation work; and c) the work of other funders and communities interested in similar efforts? • What insights can funders and researchers of similar work add to what we learn from Community-Centered Health about how to pursue community partnerships effectively?
Foundation's role	• How has the Foundation's grant funding, non-monetary support, and provision of technical assistance helped and/or hindered the progress of Cohort 1 partnerships? Specifically, how has the Foundation's support affected work around racial equity and power-building in the Community-Centered Health communities?

The chapters that follow, and are outlined below, explore these lessons and provide insights about supporting community-driven change that is productive, durable, and equitable. The report includes examples from Cohort 1 partnerships as well as perspectives from funders and researchers outside of this Community-Centered Health initiative.

- *Laying the Groundwork* discusses the **impetus for this work** and **how partnerships were established**;
- *Implementing the Community-Centered Health Vision* outlines **early implementation** efforts and introduces a **framework and key ingredients** of Community-Centered Health clinical-community partnerships;
- *Making Progress* discusses **early progress toward community-based goals**, **implementation barriers,** as well as insights related to **broader context** and external factors;
- *Moving Toward Lasting Change* outlines the **durable longer-term outcomes** and institutional transformation in communities, as well as the influence of the Community-Centered Health initiative beyond its initial goals and grantees—what we refer to as **ripple effects**; and
- *What We Have Learned* distills findings into **key takeaways about community-driven initiatives**, sustained impact, and addressing equity considerations.

Reader Tip



Keep an eye out for this symbol and distinct colors used to identify **community partnership-specific examples** throughout this report. Potentially sensitive quotes or examples are referenced generally to protect interviewee anonymity.

Keep an eye out for this symbol to identify **over-arching lessons**.

Preview of Findings

The report shows that Community-Centered Health partnerships have achieved steady progress on establishing strong, effective collaborations; making visible and meaningful changes in the community environment and in institutional practices; and attracting broader attention and dollars to address longstanding problems. At the same time, they have faced challenges along the way that they have worked to overcome, including those related to engaging partners, working through data sharing limitations, and addressing contextual barriers. Through our evaluation, we surfaced **five key lessons relevant** to Community-Centered Health grantees, the Foundation, and other funders seeking to implement similar community-led initiatives. Detailed at the end of the report, these lessons in brief include:

- **Lesson 1: Understand and intentionally respond to the influence of historic factors and broader context, being explicit about addressing structural racism.** Context matters when implementing community-driven initiatives that explicitly focus on long-term policy, systems, and environmental change because the status quo is a product of that context. The Community-Centered Health experience affirms that acknowledging systemic racism is a necessary first step to effectively build trust and address upstream health factors.
- **Lesson 2: Ensure that partnerships are committed to building trust and equity with community members and valuing the experience of residents.** Partnerships form around shared goals; however, each partner's idea of roles and responsibilities may differ. For cross-sector partnerships that center community to be most effective, partners must be prepared to move from practices of informing or consulting with community residents to collaborating and deferring to residents to drive solutions.
- **Lesson 3: Take the time to develop strong partnerships and build necessary infrastructure, which are critical to long-term and sustainable change**. Partnerships need years to solidify and build their capacity as a collaborative body before they can pursue fundraising beyond an initial grant source. In addition to supporting years-long partnership development, funders and partners also need to provide non-monetary supports and think openly about ways to measure success.
- **Lesson 4: Embrace flexibility to address emergent needs in uncertain times and set realistic expectations while continuing to track progress toward long-term goals.** Funder flexibility is important in addressing needs and issues that inevitably arise during a multi-year effort. The COVID-19 pandemic and concurrent widespread attention to racial equity spurred many Community-Centered Health partner organizations to commit more vocally to addressing racism as a public health issue. The Foundation listened and responded by bringing an interest in discovery rather, than predetermined solutions, and providing flexibility of funding and grant activities as conditions shifted.

- **Lesson 5: Scale or sustain community-driven initiatives with investment from multiple sources.** Plan for diverse multi-year funding to support scaling and sustainability once initial implementation and partnership development are underway. Once partnerships are established, cross-sector collaborations that include government and other institutions are helpful in leveraging funding for partners to access or influence. The original funder can support such avenues by articulating funding diversification as a goal and providing capacity-building training.

Data Sources

The findings in this retrospective report are based on the following sources of information. For a complete list of interview participants see Appendix A.

- **Partnership interviews:** One-on-one interviews with a technical assistance provider and Foundation staff in summer 2020. One-on-one interviews and a follow-up focus group with Cohort 1 site leaders in fall 2020, and one-on-one interviews with site leaders and partners in summer 2021.
- **Learning sessions:** Facilitated learning sessions with Foundation staff between summer 2020 and summer 2021.
- **External interviews:** Interviews with other funders and researchers of similar efforts in spring 2021.
- **Existing documents:** Review of grant documents, evaluation products, and news items related to the partnerships in spring 2021.
- **Secondary population-level data:** Analysis of community demographic and health data from secondary sources such as the U.S. Census and health departments.

Limitations

We conducted this evaluation retrospectively in 2020-2021, documenting the work of the first cohort of Community-Centered Health partnerships since 2015. With this design in mind, the evaluation has several key limitations:

- **Recall bias.** In our interviews with site leads, partners, technical assistance providers, and Foundation staff members, we asked them to reflect upon events that took place years prior to our interviews. This type of data collection is subject to *recall bias*, meaning that participants may not have accurately remembered the history of events, and/or the accuracy of their memories could have been influenced by subsequent events. In this case, participants may have been more likely to remember major successes or challenges, as opposed to incremental progress or setbacks along the way.
- **Perspectives come primarily from core partners.** Due to limitations with the retrospective design and travel restrictions during the COVID-19 pandemic, our perspective on the work of the partnerships draws primarily upon interviews with site leads and key partners. We did not interview a broad range of community residents, nor did we directly observe the work in the three communities as part of this evaluation. Thus, the findings may not fully reflect the landscape of this work or range of perspectives held by community residents involved in partnerships' efforts.
- **Limitations in information available to track retrospectively.** Related to the above, there were nuances around how the Community-Centered Health work unfolded that we were unable to capture retrospectively. This included specific details about early technical assistance provided through the Foundation and full historical accountings of the shifting context in each community. In addition, while we worked with partners to define key concepts related to this work prospectively (such as *community residents* or *shifting mindsets*), we were unable to confirm how these terms were being defined retrospectively throughout the course of the work. Given this limitation, our data collection may not have fully captured some pieces of the Community-Centered Health story.

Despite these limitations, we believe this evaluation yields useful insights and considerations for future Community-Centered Health work and other similar efforts. In addition, our evaluation benefitted from limited turnover in that many of the site leads, partners, and Foundation staff who we interviewed had been involved in the work since its inception. When possible, we also drew from multiple data sources to validate our findings (i.e., interviews, document review, and findings from other similar initiatives).

2 Laying the Groundwork

The starting elements of Community-Centered Health—a description of the partnerships in the first cohort, the Foundation's rationale and timeline for the work, and how the partnership structures took shape—provide the background necessary for understanding how Community-Centered Health progressed in its work.

The First Cohort of Community-Centered Health

Starting in 2015, the Blue Cross and Blue Shield of North Carolina Foundation supported a cohort of three Community-Centered Health grantees to test and implement partnerships in the cities of Greensboro, Gastonia, and Asheville. Each partnership was formed around a goal of addressing the root causes of a health issue important in that community (Exhibit 2). In Greensboro, Collaborative Cottage Grove aimed to address causes of chronic disease (including asthma, diabetes, and heart disease) by improving housing, access to healthy food, and creating an environment supportive of active living in the historically under-resourced Cottage Grove neighborhood. Gastonia's Healthier Highland likewise set a goal to engage the Highland neighborhood residents in community-driven improvements to support healthy eating, active living, and improving the local health care system. In Asheville, the Mothering Asheville partnership focused on alleviating racial disparities in birth outcomes, looking to implement cross-sector and community engagement strategies to improve racial equity in health care access. The graphic on the next page provides details on the County-level context and demographics for the larger regions in which each Community-Centered Health Cohort 1 partnership sits.

Exhibit 2. Community-Centered Health Cohort 1 Partnerships

Collaborative Cottage Grove

Where: Greensboro

Context: The Cottage Grove neighborhood is culturally and linguistically diverse. Years of disinvestment have led to poor and inequitable conditions.

Goal: Promote equitable community development in Cottage Grove to reduce housing-related asthma burden and improve healthy food access and community environment for all residents.

Areas of Focus: Healthy Food Access, Housing, Active Living

Healthier Highland

Where: Gastonia

Context: The Highland neighborhood is historically African American[6]. It has experienced years of disinvestment and inequitable conditions, leading to distrust of the local health center.

Goal: Build a culture of community-engaged healthy eating and active living in the Highland neighborhood.

Areas of Focus: Healthy Food Access, Active Living, Infrastructure, Health Care Access

Mothering Asheville

Where: Asheville

Context: In Buncombe County, African American babies die at three times the rate of white babies, with inequities tied to limited health care access and racism among other factors.

Goal: Eliminate disparities in infant mortality and improve pregnancy and birth outcomes for African American women and babies in Buncombe County.

Areas of Focus: Healthy Birth Outcomes, Health Care Access

[6] To honor the language and voice of the Community-Centered Health partners, this report uses both African American and Black to refer to the communities and individuals that partners serve.

Community-Centered Health County Demographics [a,b]

	Total Population	Racial/Ethnic Breakdown (White, Black, Asian, Other, Latinx)	Median Income & Percent Poverty	Percent Uninsured
Greensboro, NC	296,710	47% 41% 5% 7% 8%	$48,964 19%	12%
Gastonia, NC	77,273	63% 29% 2% 6% 10%	$49,460 17%	11%
Asheville, NC	92,870	84% 11% 2% 3% 7%	$49,930 14%	13%
North Carolina (Statewide)	10,488,084	71% 22% 3% 4% 10%	$54,602 14%	13%

a. Data source: United States Census Bureau (2021). QuickFacts Data Table Tool – North Carolina, Greensboro, Gastonia, Asheville. https://www.census.gov/quickfacts/fact/table/US/PST045219.
b. Data note: Racial/ethnic categories are not mutually exclusive. The Other category includes individuals who identify as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, or two or more races.

The Community-Centered Health Journey

The Community-Centered Health initiative emerged from the Foundation's desire to try and work in new ways to shift the health care status quo. Traditionally, health care's primary focus is on treating individuals after they are sick or injured, rather than addressing the underlying, root causes that lead to sickness and injury. Reflecting on the impetus for the work, Foundation staff shared a desire to push health care to think about "upstream" systems change and the social determinants of health. As one staff member reflected, "It was almost like we were experimenting with both how do we as a health funder move beyond health care, and how do our communities work to partner with health care, but move beyond health care?"

The work of grantees to move beyond health care officially kicked off in 2015 with an Action Learning Phase, which funded 12 organizations in different communities across North Carolina to plan and pilot community-centered capacities and partnerships over four months in a lower-stakes format.[7] As the Action Learning Phase was underway, the Foundation opened a request for proposals for communities interested in additional funding to support further planning and implementation of a Community-Centered Health project. The Foundation considered factors such as the specific capacities of each of the partnerships, their vision and staffing plan, and their ability to gather letters of commitment from both clinical and community partners. Based on early lessons from the Action Learning Phase around what it takes to build community-driven partnerships, the Foundation selected three communities to continue implementation of the Community-Centered Health approach. The three Cohort 1 grantees began implementing their partnerships' work in 2016, with the support of Foundation technical assistance grants and investments along the way. The timeline below lays out key events since 2015 (Exhibit 3).

[7] The Blue Cross and Blue Shield of North Carolina Foundation. October 2015. *Moving Upstream: Clinical-Community Partnership to Improve Population Health*.

Exhibit 3. The Community-Centered Health Journey

2015
2017
2019
2021

Action Learning Phase (February 2015)
Community-Centered Health kicks off with 12 grantees receiving small pilot grants to test and build community-centered capacities over four months.

Invitation to Begin Implementation (June 2015)
As Action Learning projects are underway, the Foundation opens the request for the first 18-month planning and implementation grant, coupled with additional funds for 12 months of technical assistance support. Three partnerships were selected for the 18-month planning and implementation phase.

Two-Year Implementation Continuation Grants (late 2017)
After a successful 18-month implementation period, Cohort 1 partnerships are invited to apply for two-year grants to continue implementation of their Community-Centered Health partnership goals.

Cohort 2 Launches (early 2019)
Drawing from the success of Cohort 1, the Foundation adds six additional communities to their Community-Centered Health portfolio.

Cohort 1 Grantees Funded to Plan for Sustainability (summer 2019)
Grantees focus on planning to carry the work forward, future partnership needs and goals, and identifying additional funding and capacity support.

Dual Pandemics: COVID-19 and Racialized Police Brutality (March 2020)
In March 2020, COVID-19 brings in-person work to a halt, followed just a few months later by highly publicized instances of racialized police violence that result in a national racial reckoning. The events directly impact the work of all nine Community-Centered Health communities.

Cohort 1 Receives Additional Implementation Grant (July 2021)
Given the impacts of the global pandemic, the Foundation decides to fund Cohort 1 grantees for two additional years of work and planning for the long-term sustainability of their efforts.

Key Features of the Community-Centered Health Approach

Since 2016, the Foundation's investment in Community-Centered Health included a combination of planning and implementation funding, technical assistance funding and support, and opportunities for grantees to engage in cross-site learning to advance their respective goals. Rather than require grantees to use additional technical assistance in a uniform way, the Foundation sought to provide a menu of supports and services that partnerships could tap into depending upon their unique needs.

The Foundation's Community-Centered Health investments in partnerships across North Carolina are defined by shared features of the approach. Exhibit 4 below describes these shared features and the key components of the Community-Centered Health investment.[8,9]

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[8] Blue Cross and Blue Shield of North Carolina Foundation and Active Living by Design. (2018). Community-Centered Health. https://www.bcbsncfoundation.org/wp-content/uploads/2018/03/Community_Centered_Health_Overview_March_2018-1.pdf
[9] Blue Cross and Blue Shield of North Carolina Foundation. Internal Document - Community Centered Health 2.0: Impact Framework (Detailed Model) (draft – v2.15.19).

Exhibit 4. Key Features of the Community-Centered Health Approach

 Core Areas of Focus	• **Clinical-community partnerships** that intentionally bring together health care organizations serving communities impacted by health disparities and local community organizations. This structure amplifies community voice in setting health priorities and supports shared, data-driven decision making to address health inequities. • Orientation to **policy, systems, and environmental changes** that focus on upstream factors influencing health and health equity. • Commitment to a **clinical shift in health care practice** that engages health care systems and providers in addressing social and systemic drivers of poor health beyond the walls of health care facilities.
 Monetary Supports	• Multi-year planning and implementation grants to grantees. Grantees had flexibility in managing their budgets as new needs and priorities emerged.
 Non-Monetary Supports	• **Coaching technical assistance** to support cross-sector collaboration and community engagement (12 hours of coaching over 12 months). • **Professional development** to support capacities associated with Community-Centered Health. • **Cross-cohort convenings** and facilitated opportunities to support shared learning and peer networking. • Additional support for partners to participate in leadership training, professional networking, conference presentations, and intern supports.

Partnership Structure

> **"At the outset it was, 'How do we test investing deeply in community… in a way that brings together these areas around both health care and social service organizations?'"**
>
> **– Foundation Staff**

Bridging clinical and community partners has been a central aim of Community-Centered Health since the outset.[10] Recognizing the wisdom and expertise in each community and building upon the Action Learning Phase, the Foundation wanted partnerships to own the work and determine how to structure their collaborative efforts to most effectively advance that central goal. As a result of the flexibility inherent to the initiative, partnership configurations vary across each community, based on community assets and priorities. In two of the communities, the lead grantee is also the primary clinical partner; in the third, a nonprofit community organization serves as the lead, though they collaborate closely with their primary clinical partner. In addition to grantee leads, each partnership includes numerous organizations and individuals, with representation across multiple sectors and community demographics. Exhibit 5 outlines a subset of each community's current core partners, identified during interviews in 2021.

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[10] The Blue Cross and Blue Shield of North Carolina Foundation. (2015). Blue Cross NC Foundation Strategy: Bridging Clinical and Community. Retrieved from https://www.bcbsncfoundation.org/wp-content/uploads/2015/10/TheoryOfChange_5-12-15.pdf. Accessed November 15, 2021.

Exhibit 5. Key Community-Centered Health Partnership Members

Collaborative Cottage Grove

- Greensboro Housing Coalition (**Lead**)
- Cone Health (Clinical Partner)
- Community Residents & the Cottage Grove Neighborhood Association
- Mustard Seed Community Health Clinic
- New Hope Community Development Group

Healthier Highland

- Gaston Family Health Services/Kintegra Health (**Lead and Clinical Partner**)
- Community Residents & the Highland Neighborhood Association
- CaroMont Health
- City of Gastonia
- Gaston County Department of Health & Human Services
- HealthNet Gaston

Mothering Asheville

- Mountain Area Health Education Center (MAHEC) – Ob/Gyn & SistasCaring4Sistas Doula Program (**Lead and Clinical Partner**)
- Asheville Buncombe Institute of Parity Achievement
- Buncombe County's Nurse Family Partnership
- Children First/Communities in Schools
- Community Residents in the Pisgah View Apartments
- Mount Zion Community Development
- Pisgah Legal Services
- YWCA Asheville

As the scope and scale of the Community-Centered Health work has expanded over time, so have the partnerships. Different members have joined or departed, but each partnership typically includes the following:

- A range of nonprofit organizations addressing health, advocacy, legal services, and social justice, among other areas of expertise.
- Health care clinics, hospitals, and health care networks.
- Leaders and representatives from city government and county agencies.
- Neighborhood associations.
- Faith-based organizations.
- Educational institutions.

3 Implementing the Community-Centered Health Vision

From the early days of Cohort 1 and throughout the Community-Centered Health initiative, the partnerships have engaged in ongoing development of their collaborative capacities. As this chapter details, Community-Centered Health partnerships not only required established organizations to work together, but also elevated community residents as leading voices in each partnership's priorities and strategies. How the partnerships have built these capacities, and the range of supportive measures the Foundation offered, provides constructive examples for community-based partnerships more broadly.

Examining Community-Centered Health implementation and engagement with both cohorts of grantees allowed the evaluation team to develop a better understanding of the nuance of how community-centered work takes place. Through a listening session with Cohort 1 grantees, input from Cohort 2 grantees through an evaluation advisory group, and other data collection activities, we explored the core components and common outcomes of the Community-Centered Health model. These engagements, coupled with input from the Foundation and insights from other similar initiatives, informed our development of an Impact Framework that visually depicts the initiative's approach and primary elements. The framework and a detailed look at key ingredients of effective clinical-community partnerships offer further tools and insights relevant to continued Community-Centered Health work, as well as other community-led health efforts.

Early Implementation

Identifying a core group of aligned partners to advance the Community-Centered Health work was a critical first step. However, to shift the health care status quo and make progress toward community-driven systems change, partners also had to reflect upon existing community engagement strategies (if they were in place), and establish new modes of community partnership, particularly in the earliest stages of the work.

Looking retrospectively at Cohort 1's work puts into perspective a fuller arc of community engagement and highlights how the partnerships transformed their ways of working with community residents over time. The Movement Strategy Center's *Spectrum of Community Engagement to Ownership*, adapted into a visual in Exhibit 6, highlights how this transformation can take place. While this framework was not adopted at the outset of the work, it provides a helpful lens through which to retrospectively track how Community-Centered Health partner organizations shifted their stance toward community members to build community power.[11]

> "It was about listening to the residents and getting information and letting them tell you what they need, instead of sitting in our office and saying, 'I think this community needs this.'"
>
> – Healthier Highland partner

[11] Movement Strategy Center. The Spectrum of Community Engagement to Ownership. (2019). Retrieved from https://movementstrategy.org/wp-content/uploads/2021/08/The-Spectrum-of-Community-Engagement-to-Ownership.pdf. Accessed December 7, 2021.

Exhibit 6. Spectrum of Community Engagement to Ownership

Stance toward community	0 IGNORE	1 INFORM	2 CONSULT	3 INVOLVE	4 COLLABORATE	5 DEFER TO
Impact	Marginalization	Placation	Tokenization	Voice	Delegated Power	Community Ownership
Community engagement goals	Deny access to decision-making process	Provide the community with relevant information	Gather input from the community	Ensure community needs and assets are integrated into process & inform planning	Ensure community capacity to play a leadership role in implementation of decisions	Foster democratic participation and equity through community-driven decision-making; Bridge divide between community & governance

Many of the residents in the Community-Centered Health communities were distrustful of systems that have not historically served them well, and of "grants and initiatives [that] have come and gone as fast as the snap of your fingers." As a result, significant effort during the initial stages of work went toward creating spaces where the role of partners was to listen to community member needs and identify ways to act toward tangible changes. Community-Centered Health partner stances toward community varied at the outset, but changes over time included a move from **informing** or **consulting** community residents to **collaborating with** and, finally, **deferring to** residents as the experts. Each community's experience and operationalization of this engagement process took a different form and may not have been as linear as this spectrum may imply. Exhibit 7 provides examples of how partner practices evolved over time as partners created the conditions for community ownership early on in Community-Centered Health.[12]

Exhibit 7. Spectrum of Community Engagement to Ownership in Practice

Stance	INFORM	CONSULT	COLLABORATE	DEFER TO
Examples from Community-Centered Health	Sharing back with community in town halls. Early partner efforts focused on traditional modes of informing community members. In one partnership, the city council held town hall discussions with residents, "something that had not happened in recent memory." This first step toward more effective community engagement was meaningful in building trust, with residents feeling that "their voices were not just being heard but being considered."	Building community voice into planning and project design phases. Some collaboratives launch with pre-set ideas of what communities need or want, but the Community-Centered Health partnerships chose a different path. Rather than draw upon assumptions, they implemented activities, such as community needs assessments, resident focus groups, and partner surveys, to understand community needs and issues that partners were grappling with.	Committing to building community residents' capacity and power to serve as leaders. Beyond creating space for community residents to voice their needs, early activities focused on providing residents with leadership training and skills to feel comfortable doing the work. This included training sessions, establishing resident-led committees, and creating infrastructure and procedures that continue to guide the partnerships in making critical decisions to this day.	Community residents are leading the way across Community-Centered Health partnerships. For example, residents in one community "established a Neighborhood Association as a 501c3 non-profit organization, including drawing up bylaws, electing officers, and participating in fundraising training to be better able to sustain their community organizing and advocacy efforts." The residents actively lead and drive community-centered solutions.

[12] This graphic provides illustrative examples of how some of the stages of community engagement played out within partnerships, but is not intended to represent every stage or step of the framework. Additionally, the evaluation saw evidence of these steps across multiple partnerships, and thus these changes are not meant to represent the work of one partnership specifically.

As community residents have stepped into leadership roles across all three of the Community-Centered Health partnerships, many of the core partners continue to operate as advocates and allies, ensuring that local governments and health systems are responsive to community needs. Additional exploration of implementation efforts and the successes that have resulted from intentional community engagement and power-building are covered below and in Chapter 4.

The Funder's Role: Modeling Values and Practices through Supportive Technical Assistance

Beyond dollars, the Blue Cross and Blue Shield of North Carolina Foundation's investment in Community-Centered Health has included a commitment to supporting communities by fostering the leadership, connection, and capacity building that is central to the work. This has taken the form of **cohort-wide convenings** and ongoing **training**, as well as **coaching**. Interview participants reflected that the Foundation made a concerted effort to stay responsive, meaning that their approach to supporting grantees evolved as new needs emerged.

- All three of the partnerships pointed to the importance of intentional **cohort-wide convenings** to support grantees in advancing new and complex work. Early in the work, convenings took the form of monthly facilitated conversations, although they evolved to include different topical areas and trainings over time. As one grantee reflected, "The thought partnership that convening [together] allowed us to participate in" was integral. Others highlighted the value of peer networking, as well as the importance of gatherings to support team morale, particularly prior to COVID. Reflections on similar work funded in Texas confirm the importance of these types of spaces in providing the foundation for collaborative work to flourish.[a] As one funder described, "Convenings were really important [for grantees]. Particularly as organizations are learning and inculcating new behaviors and operating procedures, it's really important for them to get support from their peers, and say, 'Well how'd you do this?'"
- Community-Centered Health partners also highlighted the value that the different forms of **coaching** provided over the course of their work. Coaching has taken different forms over the course of the initiative. At the outset, for example, coaching supported grantees to work toward conceptualizing and implementing stronger community engagement. As the work progressed, coaching focused on supporting organizations to work toward their racial equity goals. One Community-Centered Health grantee described early coaching as vital, stating, "I do not believe we'd be where we are right now without the coaching that we received." Grantees noted that the Foundation's approach to coaching demonstrates their commitment to being responsive and flexible in their efforts to best support grantees. Early in the initiative, the Foundation supported a coaching approach that was more structured, with Foundation-identified partner organizations coaching grantees as they established key elements of their work. As partnerships became more established, the Foundation shifted its coaching model, with the Foundation providing grantees with additional funding to directly identify consultants according to their own needs.
- In addition to building grantee skills, content-specific **trainings** have helped partnerships advance critical aspects of their work at the local level. Interview participants noted that the Foundation's willingness to extend training resources to other community partners and members helped to ensure the trainings had an impact. One grantee, for example, highlighted an early diversity, equity and inclusion training offered by the Foundation. The site lead's decision to invite a local city official to attend the training created a powerful ripple effect. City government moved from "wanting to do more around equity…to now [having] a Diversity, Equity and Inclusion Director" and requiring city employees to undergo regular equity training. Interview participants cited other trainings, such as more recent facilitative leadership trainings, as also being important across partnership sites. One partner and community member called this topic "life changing" because it provided them with new skills and offered them space to engage in leadership development they would otherwise not have been able to access.

[a] For more information on the Episcopal Health Foundation's work in Texas: https://www.episcopalhealth.org/grantmaking/community-centered-health-homes/

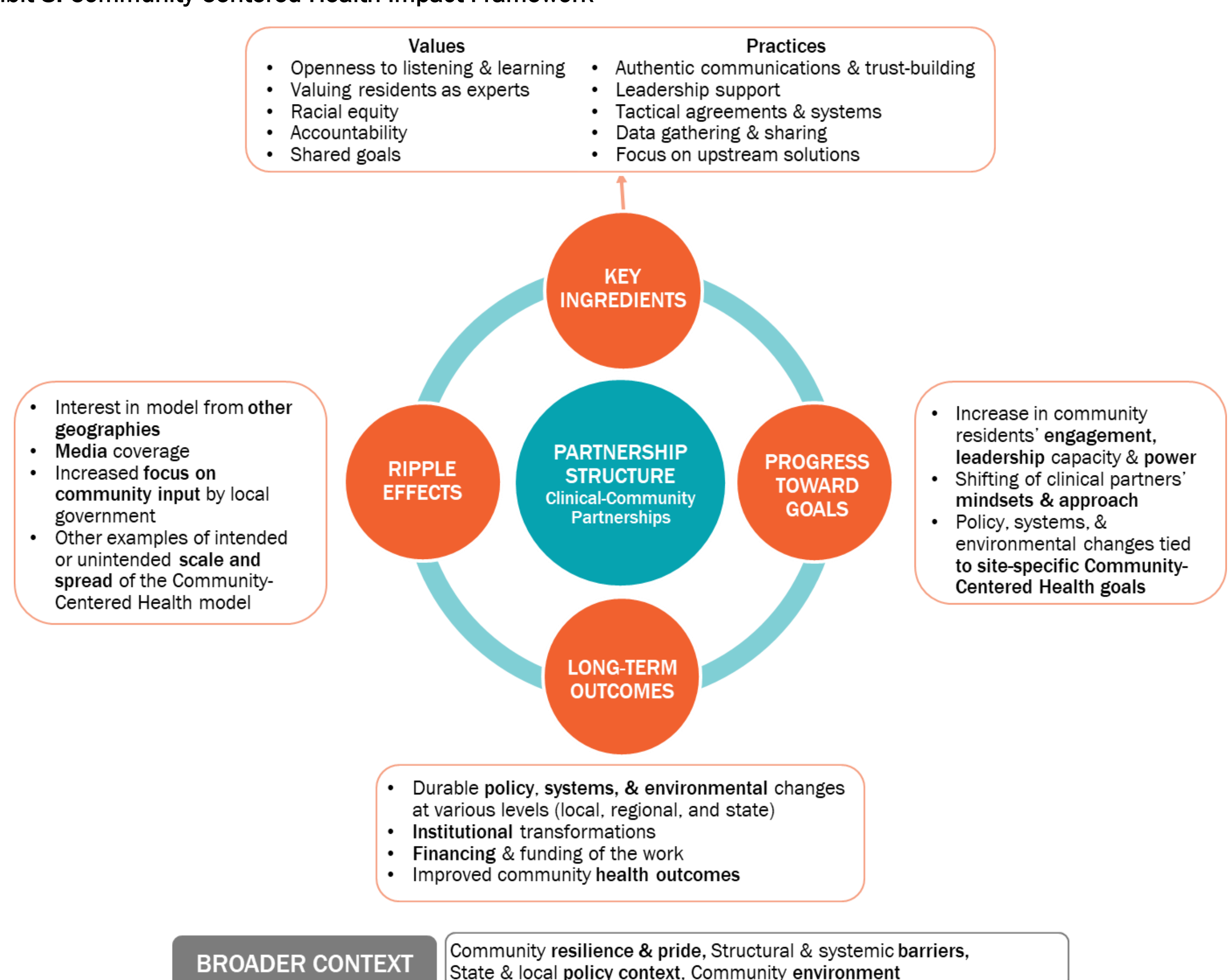
Community-Centered Health Impact Framework

To better understand and explain the ways in which Community-Centered Health partnerships are making an impact locally, the evaluation team developed the *Community-Centered Health Impact Framework* (Framework), shown in Exhibit 8. This Framework offers a visual model for understanding and documenting progress, drawing upon early iterations of the initiative's theory of change; input from Foundation staff, Community-Centered Health grantees and partners; and the literature on community-based partnership impact and measurement (see Appendix B).

The Framework provides a visual representation of the Community-Centered Health approach and shows its critical elements, drawing upon the experience of both Cohort 1 and Cohort 2 grantees. As the framework illustrates, the central **structure** of clinical-community partnerships serves to develop and harness **key ingredients** to make collaborative **progress toward goals** and durable **long-term outcomes**. Because Community-Centered Health aims to change how clinical partners address health and integrate community input into decision making more broadly, its design enables **ripple effects**, with influence beyond initial goals and outcomes. The framework also accounts for the **broader context** in which each partnership operates, including community social and environmental characteristics; historical legacy; policies; and structural and systemic factors. The following chapters of this report highlight how Cohort 1 partnerships have made progress in different areas aligned with the Framework.

Lastly, the elements shown in the Impact Framework highlight pathways for change and progress and define areas that this evaluation report explores. However, the Framework does not fully depict the complexity inherent in any effort to transform communities. For example, it does not fully depict the emergent and cyclical nature of the work.

Exhibit 8. Community-Centered Health Impact Framework



Key Ingredients of Effective Clinical-Community Partnerships

As the evaluation sought to understand the early phases and trajectory of each partnership's work, it became clear that common values and practices undergird successful Cohort 1 partnerships. Our interviews and reflections during the retrospective evaluation allowed us to further explore which of the **Key Ingredients** listed in the Impact Framework above were most central to the work of Cohort 1 grantees. Exhibit 9 describes a subset of key ingredients from the Framework, highlighting those that Cohort 1 grantees and partners referenced in our 2021 interviews. Descriptions of these key ingredients, along with examples of how they serve partnerships well, show why they are important not only to the Community-Centered Health initiative but also to community-based efforts more broadly.

Exhibit 9. Key Ingredients of Effective Clinical-Community Partnerships

Key Ingredient	How It Works	Partnership Perspectives
Addressing structural racism	Effectively addressing the health disparities that many communities experience today ultimately requires partnerships to step back and make explicit a primary root cause of poor health: structural and institutionalized racism. As one partner reflected, their community has contended with "hundreds of years of racism, discrimination, and not being heard." The work of addressing structural racism is not easy and action often requires collaborative partnerships to generate buy-in across a range of diverse partners—some of whom may not believe that structural racism is an issue within their community. Progress in this area requires the commitment of partnerships to a shared vision of examining and pushing back against racist systems, and a range of strategies that includes many of the key ingredients listed below.	*"The great thing about the Mothering Asheville effort is—because it drew out of analysis that included systemic racism and health outcomes and policy—a lot of the members were instrumental in helping pass the resolution of racism [as] a public health crisis… The members around the table, both, collectively and individually, have continued to lift up and make sure that that analysis of racism and white supremacy have been part of the public health conversation in this county."* - Mothering Asheville Partner
Cross-sector commitment to a shared vision	To achieve strong, collaborative cross-sector partnerships, each partner must come to the table ready to work toward a common goal. The work is complex and lengthy, requiring genuine engagement by those involved, and the ability to set aside individual egos to work towards a shared vision and goals. A representative from Collaborative Cottage Grove emphasized the centrality of alignment and commitment, saying, "We have seen it happen where people may want to jump on board because you're getting recognition, but it doesn't work like that. You're in it for the long haul, bringing your organization in, getting data, and meeting the residents, and using it for the good of the community."	*"We have amazing collaboration—a group of community partners that are all aligned around the same mission of eliminating the racial disparity in birth outcomes. We're ensuring that moms are getting strong representation and good education, but also trying to do the work of addressing the systems that enable that disparity. You'll hear people say Mothering Asheville is a movement. It's not just one organization, it's a movement of organizations that work together towards a common cause."* - Mothering Asheville Partner
Valuing community	When a partnership centers community, it values lived experience and recognizes community leaders and members as experts on what solutions are needed. In Cohort 1, integrating local voices at the table and actively soliciting community input to inform partnership actions emerged as key practices. As a Healthier Highland member	*"Because the leaders of the Collaborative Cottage Grove, like myself, come from communities like Cottage Grove, we're more relatable. The residents talk to us freely because there is that lived experience and their contribution is always valued and appreciated.*

Key Ingredient	How It Works	Partnership Perspectives
	remarked, “When a health department is meeting with a regular member of the community, when the head of a big firm or health organization is sitting right across the table from a community member, that speaks volumes to them and says [they’re] cared for. Somebody wants to listen. Those are the things that closed gaps in our community.”	*It's important to have your leaders in a project representing the community. A lot of times, we have outsiders making decisions for people and that's why there's been a lot of distrust in Cottage Grove and other distressed communities. We're hoping to change that through Community-Centered Health.”* - Collaborative Cottage Grove Partner
Building trust through action & over time	Related to *valuing community* is the idea that developing authentic, trusting relationships takes time and requires actions that substantiate words. A member of one community commented that undoing existing mistrust is part of the process, noting, “There's a lot of mistrust with systems in general. A lot of times, there's an underestimation of how long trust takes to build. We have to invest in people and communities to help build that trust.”	*“The city has done every foul thing you could do to the neighborhood over the years. [A current city department leader] was not responsible for any of it. But he went [to the community] and said, ‘I'm here and I want you to know I can't undo what's been done, but you tell me what we need to do from this point forward and that's what we'll do.’ And [residents would] say, ‘Well, you need to fix that light up there at the recreation center.’ The next day it would be fixed. They'd be like, ‘Okay, well, you need to do this.’ They tested him out for a while. He kept following through. He earned their trust.”* - Community-Centered Health Partner
Realistic expectations	Making progress on community-wide cross-sector work is a long endeavor with countless small steps and regrouping after missteps or setbacks. Viewing these challenges as opportunities to learn and build resilience can ultimately make the partnership more effective. A member of Healthier Highland cautioned not to try to do too much at once, saying, “We were very honest about what can be done and how it needs to be done. Sometimes it takes small steps. Being flexible and positive about things is important and we celebrate those small wins.”	*“When we’re coming together, we might not get it right. We’re going to make some mistakes. But as you fall forward, you learn from it. That’s what garners success.”* - Collaborative Cottage Grove Partner
Data sharing agreements	Funders and researchers outside of the Community-Centered Health initiative agreed that data sharing was an essential component, and one that needed attention from the start of a partnership. Echoing others, an evaluator of a similar initiative cautioned, “Figuring out how to align those data systems is really hard, and often takes a lot longer than everyone anticipates or really wishes it would take.” Community-Centered Health partners commonly spoke of valuing data as key to informing, tracking, and communicating their work, but many spoke of establishing systems for sharing data as an ongoing process.	*“A lot of our work is data driven. [We’re] trying to get that integrated into our partnership, because our faith-based organizations and local community-based organizations may not have capacity to have a data tracking person. We’re getting people used to collecting data because we have to show that we are making progress in the community.”* - Collaborative Cottage Grove Partner

Although common key ingredients emerged across partnership sites, these ingredients are not static. They may be operationalized differently over time, depending on the community or the evolving nature of the work, and as a result, require partners to revisit and reflect as an ongoing practice.

The Hard Work of Building Collaborative Partnerships

To work toward Community-Centered Health goals and outcomes, funded partnerships have had to evolve from partners in name to partners in practice. Effective partnerships did not come together overnight. They were the result of more than five years of intentionality and effort to develop collaboratives that looked and felt different, both for partners traditionally involved in collaboratives, and most importantly, for community residents. The Impact Framework above outlines several key ingredients that have helped each partnership thrive, such as honest communication and building trust over time by consistently showing up, listening, and taking action to meet community-defined needs. The achievements of Cohort 1 partnerships described throughout this report relied on this foundation of meaningful collaboration.

Collaborative Cottage Grove exemplifies the challenge--and ultimate benefit—of forging solid working relationships across sectors when partners come to the table with different ideas about whose voices are important and how to make decisions. Many partnerships require time and a strong commitment to shared goals and values to develop into effective collaborations. In mid-2020, one Collaborative Cottage Grove member spoke of difficult dynamics as the group sought cohesion, commenting, “You have power dynamics, particularly with the clinical community. Their way is the way it should be—heavy group dynamics in a very negative way. Despite those dynamics, the group is still here working together, a testament of the longevity and deep-rooted understanding that we should be doing this to help the community.”

About a year later, the same member reflected on the benefits of that partnership. “Because [Community-Centered Health] required you to partner with a medical provider, that opened doors and opportunities for us to partner with others and build relationships with others in the medical field that we wouldn't have without that requirement,” they said, adding, “That wouldn't have happened naturally.” A member of that partnership on the clinical side agreed that despite challenges, the partnership was successful. “Now mind you,” they stated, “you're going to have hiccups in anything that you do. But at the end of the day, this is truly a collaborative effort where you see positive impact of the collaboration.”

A researcher outside of Community-Centered Health added the perspective that sustained grant funds are necessary to help cross-sector health collaboratives become established. For initiatives to have staying power and, eventually, the ability to bring in outside funding, they need multi-year support focused on building structure and stability. Partnerships with capacity to pull in and manage additional funds, the researcher contended, have usually “been around for more than three years. They’ve built the collaborative muscle, the collective will to do that kind of stuff. There’s something to be said for providing the time to build up toward that.”

4 Making Progress Toward Goals

The Foundation's Community-Centered Health approach identified three goals for the partnerships to work toward, including increased community engagement and leadership capacity; broader clinical commitment to upstream and community-based health solutions; and policy, systems, and environmental changes that support the partnership's work. This chapter presents findings related to how core partners worked together to establish partnerships grounded in shared values and practices; the partnerships' early progress in demonstrating an increased role for community in the health landscape; and barriers influencing implementation.

Early Progress Toward Goals and Outcomes

Community-Centered Health partnerships demonstrate how community-driven collaborative efforts can leverage a foundation of shared values and practices to work toward visible and durable community transformation. Once the groundwork was laid, partnerships began engaging in activities that would support their longer-term goals, including building community capacity and leadership, as well as shifting mindsets among key stakeholders involved in the work.[13] Exhibit 10 summarizes examples of progress that each Community-Centered Health partnership achieved and is followed by detailed findings for each community.

Exhibit 10. Summary of Cohort 1 Progress Toward Community-Centered Health Goals and Outcomes

Area of Progress	Collaborative Cottage Grove	Healthier Highland	Mothering Asheville
Community engagement & leadership capacity	• Clinical-community integration leads institutions to seek community members' knowledge.	• Community members are now changemakers with government and clinical partners actively listening to and engaging them. • Community members hold decision-making power and make decisions that affect their community.	• Community leaders established a needed doula service "for women of color, by women of color."
Shifting mindsets and approaches of clinical and government partners	• The partnership has catalyzed tangible improvements to health access by linking residents to health care and bringing other needed resources into the community.	• The partnership prompted a clinical partner to develop a robust community health worker program that employs local residents. • The city of Gastonia has developed strategies to connect with community members to gather their input on what is needed and to inform future work.	• The partnership is putting community voice and interests first to remove the racial inequities that impact health outcomes for African American women and children. • The clinical partner embedded three community-based doulas into the clinic.

[13] Though no formal definition of "shifting mindsets" was applied to this work at the outset, many of the partners used this term to describe the ways that they leveraged Community-Centered Health efforts to develop a shared understanding of community issues and push for greater commitment to addressing these issues among traditional powerholders, such as health care institutions and local government.

Community engagement & leadership capacity

Partnerships built community engagement and expanded community-based leadership by putting residents at the center of the work. Their progress demonstrates the community power and influence that has resulted from each partnership.

Collaborative Cottage Grove

> "The authenticity and collaboration are very powerful. It's not my way, it's not your way, it's finding other ways to really solve problems."
>
> – Collaborative Cottage Grove partner

- **Institutions now seek community members' knowledge** and experience as the partnership has broadened organizations' perspectives on community health. A clinical partner reported, "We're creating the space for people to have real talk to build their capacity to advocate for things that need to happen in their neighborhood. The engagement with community, neighborhood association building, and building up the leadership to be able to run these things—they are successful outcomes as a result of taking the time, pausing, listening to what really matters." Another partner who is a nonprofit director noted,

  "Because of that model of clinical-community integration, we were able to hire from within the community and demonstrate that hiring from the community gives you a level of expertise and know-how that you wouldn't get from folks just coming in with some special credentials. The clinical-community partnership also gave us an opportunity to recognize what we wanted from the clinical [partners] and what we needed. It gave us a framework on how to work with a larger health system."

Healthier Highland

Photo Credit: Healthier Highland Facebook

- **Community members are now change makers,** with government and clinical partners actively listening to and engaging them. According to one partner,

  "The biggest thing I've seen is the activity of the residents in the Highland community and them taking ownership. The community pride has grown 100-fold since we started. They do community cleanups and have adopted part of the rail trail that we have. We do walkthroughs of the rail trail every year. Anything the community wants and needs, they've found a way to do. It's not like, 'Oh that's really big. Maybe we shouldn't do that.' The residents are like, 'Okay, let's strategically look at this and understand it and bring it in and have a discussion.' And then we find a way to support them. Empowerment of the residents, that self-realization and pride in the community has changed a lot."

- **Community members hold decision-making power.** "We've become the gatekeepers for all things in this community," stated a partner, continuing,

  "If you want to start something and want it to be successful and sustainable, then the Healthy Highland Group is the group to go to. It's up to the community to decide if there's something that should be pursued. Right now, we have a substance abuse coalition courting the Healthier Highland Group because they want to garner support to bring about successful programming as it relates to opioid and substance abuse issues and concerns."

  This prominence serves to draw additional interest. Another partner commented, "As we take on new partners, we're able to experience more people wanting to be part of the success."

Mothering Asheville

- **Community leaders established a needed doula service.** Describing itself as a doula program "for women of color, by women of color," SistasCaring4Sistas, or SC4S, is a new entity that came out of the Mothering Asheville partnership to take community ownership of addressing disparities in maternal health and infant mortality.[14] As a partner remarked, "I'm amazed and proud that this work has led to the creation of something like SC4S for this community. The vision and leadership from the SC4S staff have been inspiring. Helping to launch SC4S through Mothering Asheville was the most tangible outcome."

Shifting mindsets and approaches of clinical and government partners

Community-Centered Health has led some clinical and government institutions to adopt practices that move them from listening and creating space for community input to ceding power to the community to drive solutions. A researcher outside of Community-Centered Health underscored such shifts as key precursors to achieving lasting outcomes, saying, "Shifted mindsets across lots of key stakeholders and new relationships built across sectors [are] things that give us confidence that we're moving towards change."

Collaborative Cottage Grove

- **The partnership has catalyzed tangible improvements to health access.** Interview participants reported that a clinical partner is collecting and using patient data on social determinants of health to assess 'hot spots' and connect patients to broader resources. While not a direct outcome of Community-Centered Health, the partnership's lead health center opened its doors in 2015, providing access to much-needed health services in a community lacking a doctor's office for almost 30 years.[15] As a partner pointed out, having the health center play such an integral role in the partnership and, "Bringing [them] directly into the community, right there on the main thoroughfare, has helped to make people more aware and make people utilize the services of a medical facility."

Healthier Highland

- **The partnership prompted a clinical partner to develop a robust community health worker program.** As a partner explained, "We hired our first community health worker, and their role has expanded and created an entire department here at [our organization]. We now have a community health worker in each of our clinics making sure someone has access to medication assistance or is signed up as a new patient. They are the connector between the clinic and the community."

> "[The city of Gastonia is] pursuing Community-Centered Health themselves. I don't think we saw that coming."
>
> – Healthier Highland partner

- **The city of Gastonia has also developed strategies to connect with community members.** Partners reported that the city is hiring a liaison so that every neighborhood has a resource to hear residents' needs and connect them to services. A city representative described the new perspective, saying, "I don't need to go in a community and tell them what I think they need. I just need to listen to the residents. They're an expert in their own community. If we listen to them, not only do we get the buy-in right away but we're delivering things that they want and are going to use and benefit from. It's a win-win proposition."

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[14] SistasCaring4Sistas. (n.d.) Home [Facebook Page] Retrieved from https://www.facebook.com/sc4sdoulas/?ref=page_internal.
[15] Mustard Seed Community Health. For Cottage Grove residents in east Greensboro, this clinic is just what the doctor ordered. Retrieved from https://mustardseedclinic.org/uncategorized/greensboro-news-record-for-cottage-grove-residents-in-east-greensboro-this-clinic-is-just-what-the-doctor-ordered/. Accessed December 3, 2021.

Mothering Asheville

- The partnership approaches its relationship building through a lens of **putting community voice and interests first.** As one partner described it, Mothering Asheville has made a "commitment to centering community voice, examining the impact of racism across health care, in community, and across policy, and then building the relationships that have grown out of this collaborative."
- Working to establish stronger communication with community members, the **clinical partner hired three doulas through SC4S. They are community residents themselves**, and experts in connecting with community members and knowing what resources exist within their client's communities.

Photo Credit: SistasCaring4Sistas Facebook

Barriers to Implementation

Partnerships and collaboratives commonly experience challenges, especially when the focus is on shifting broader systems and entrenched mindsets, as was the case for Community-Centered Health partnerships. Beyond the recent effects of the COVID-19 pandemic and other external challenges (for example, those described in the Broader Context section below), partners described factors within their partnerships that periodically slowed or delayed progress over the past five years. These barriers, including difficulties engaging a full range of partners, working with the inefficiencies of partnerships, and limited data sharing from clinical partners, hold relevance to clinical-community collaborations broadly (Exhibit 11).

Exhibit 11. Barriers to Community-Centered Health Progress

Barrier	Description	Partnership Perspectives
	Partnerships struggled to get some organizations or agencies of interest to join the conversation and share resources. In some cases, they identified resistance to community-led decision-making and attachment to traditional views of expertise that devalue lived experience. Particularly when influential players are not on board, the partnership may have less effect on policy, systems, and environmental change.	*"Our county had a history of trying to get the best PR it could, not necessarily being engaged as authentically as it needed to be. Mothering Asheville experienced some turbulence at times with that."* -**Community-Centered Health partner**
Some partners' resistance to community-led decision-making	A researcher external to Community-Centered Health suggested that placing resources in community hands helps counteract power imbalances by ensuring community voice in spending decisions. In grant-funded partnerships, they noted, "If the lead agency is a clinical agency, a governmental agency, a nonprofit, or a community-based organization, there are pros and cons for each, including in terms of power and capacity building. There is an argument that initiatives like these should push the power dynamic by requiring that resources be housed at the community level."	*"Our hospital system [doesn't] have any diversity, equity, and inclusion staff...We keep trying and hoping they'll get more engaged. They seem to look inward all the time at self-preservation instead of outward to the community. That is a constant source of disappointment because they have so many resources. Sometimes there are people that don't think voices should be heard and that can be a barrier."* -**Community-Centered Health partner**

Barrier	Description	Partnership Perspectives
Challenges coordinating multiple partners around shared goals and objectives	A group of organizations and individuals working in a partnership is limited in its agility by the need to come to consensus on actions and to coordinate and lead a wide range of members who are also balancing other workplace responsibilities and agendas. Partners mentioned the challenge of managing a partnership as well as effectively planning for leadership transitions and building leadership capacity.	*"When you're [a] smaller [organization], you're nimbler and can get stuff done. With [partnerships] it takes a little bit longer to do stuff. And, of course, there are silos. People start doing stuff and duplicate versus bringing the issue to the person who can solve it."* -Collaborative Cottage Grove partner *"How do we make a sustainable embedded system that's run by a series of organizations instead of just one or two people? If one or both of those people go away, then [those left] are trying to figure out what to do next and who has capacity. So capacity building—I'd love to see that."* -Mothering Asheville partner
Limits in data sharing that prevent tracking of progress	In part due to policies around patient privacy, setting up data sharing agreements with clinical partners can be challenging, yet the data is key to tracking partnerships' progress toward goals. Multiple partners within Collaborative Cottage Grove, especially, mentioned formidable challenges that only recently have begun to ease. Others noted that availability of local data that can be disaggregated by race and gender is critical to showing disparities. These comments echoed challenges that funders outside of Community-Centered Health have also raised, and they gave rise to data sharing agreements emerging as a key ingredient for effective clinical-community partnerships.	*"You get national funders like Blue Cross and Robert Wood Johnson and we can't get the health system to figure out how to share the data. I need my funder to back [us] up. If you're going to tell us to engage with the clinical community, to integrate it, then there needs to be an assessment of readiness and a confirmation that they will have the capacity to learn and to share."* -Collaborative Cottage Grove partner *"In the county health reports, we are an annual top performer in terms of access [to health care]. However, that access point doesn't pan out when you look at gender and race. There's a disparity."* -Mothering Asheville partner

Insights About Broader Context

While the early implementation efforts described in Chapter 3 facilitated the Community-Centered Health work, the partnerships' experience also shows how the political and social context affects the ability of a clinical-community partnership to thrive. The following themes illustrate how Cohort 1 partnerships have experienced and responded to the environment in which they work.

Structural and systemic barriers

- **Legacies of racism, inequity, and corruption have contributed to community mistrust and underscore the need for community-centered work.** In all three partnerships, members pointed to a deep history of racism as a cause of the inequities they are addressing through Community-Centered Health. Cottage Grove, for example, according to one collaborative member, "historically was a Black community in Greensboro. Black professionals, doctors, and businesses were really successful in the '50s and '60s. Then, a lot of change and disinvestment continued to happen. So, Cottage Grove has disparities in health and the inequities today with high rates of asthma among children, diabetes, and hypertension." Greensboro was also the location of significant non-violent civil rights actions, such as the Greensboro Sit-in. Inequities resulting from that disinvestment are what Collaborative Cottage Grove now seeks to reverse.

In one community, where large racial disparities exist in economic and health outcomes, experiences with corrupt officials have further undermined community trust. As a partnership member described it, "Our former county manager and assistant county manager are now in jail due to a long-term issue of funding kickbacks and things. The last time I saw, that investigation was still open, so there's this question of who are they still looking at. The county's credibility and trust has had some issues." This partnership has come together around a vision of advancing equity through a trusted, cross-sector coalition.

- **Entrenched mindsets among some elected officials present barriers to rethinking power dynamics and improving equity.** Decision makers at local or county levels who resist a shift from the status quo to a community-centered approach can impede progress of equity-focused work. In one community, while the head of the health network has been an influential supporter of equity work, one partner pointed out a contrast with county government officials who have been less receptive to integrating equitable practices. They noted, "Our CEO has always championed equity and diverse voices, so I felt protected. But when you work for the city or county government, that's not always the case…" Another partner concurred, "When you have a long history of a certain group of people who are used to running things a certain way, and then you come in and say, 'Hey, let's do it this way,' there's a lot of tension there."

Local and state policy context

- **Longstanding neglect by government and businesses means residents have little access to resources and services.** A Collaborative Cottage Grove partner, for instance, remarked, "One thing we struggle with is that when you are serving and living in what folks call a 'marginalized community', the resources that are in other parts of town are not available for our side of the city. We don't often get the funding or the resources, even the roads. We just lack some things that other parts of the city get." Grantees and partners also described challenges with the state's decision not to expand Medicaid to align with the Affordable Care Act, which has disproportionately affected communities with more low-income residents. As a Healthier Highland member described it, "North Carolina's failure to expand Medicaid was tough. In Gaston County, low-income uninsured people can't access health care. It is hard. We're still advocating for that to change. People don't really understand Medicaid. They hear, 'We've got to control costs.' Well, we're throwing away money in North Carolina. That same mentality that doesn't want to expand Medicaid makes being poor people's fault."

"We were seeing all those social determinants and indicators for prosperity and well-being go in a very alarming direction. We have the highest rate of unemployment for Blacks in the state. Our Mothering Asheville coalition [determined] that our true north would be equity going forward."

– Mothering Asheville partner

Community strengths and evolving environment

- **Resilience and determination counteract challenges.** In the face of racism and deep-seated inequities, community members persist. Describing the context in Gastonia as "inherently unfair, inequitable," a Healthier Highland partner said of Highland residents, "You know what? They keep plugging away. I'm amazed at all I've learned about resilience from that community." A partner of Mothering Asheville described "how hazy and foggy [Community-Centered Health] felt when we first got invited to some of the planning," but "to see this group of people really just jumping in to learn and stumble and trip, but to keep coming back," showed a determination and staying power that inspired this speaker and others to commit to collaborative action.

- **Demographic shifts can provide impetus and opportunity for change.** Over time, communities have seen increased demographic diversity and representation. In both the Collaborative Cottage Grove and Healthier Highland partnerships, members remarked on increases in community diversity as immigrant and refugee populations have grown and census reports have substantiated the shifts they observe. The changing population affects community priorities and who is represented among

"[Achieving outcomes] doesn't happen without the support, the input, and the work of the community that you serve."

– Healthier Highland partner

decision makers. As one partner in Healthier Highland noted, “Those voices have been raised in Highland as a result. The city council in Gastonia is the most diverse it’s ever been. There are more diverse voices at the table and that makes a difference.”

- **Developing collaborative relationships with willing government partners expands opportunities for communities to influence decisions.** The Community-Centered Health Cohort 1 partnerships have flourished in part because all three have succeeded in actively engaging political leaders. A Mothering Asheville member, for example, explained, “We have a strong representative at the county. Having advocates like that really pushed the county health department and county commissioners to do things like naming racism as a public health emergency. It continues to validate the work happening through Mothering Asheville. That has been incredibly supportive.” In another community, a partner commented, “[Having local community members engaging with the city council, and even elected to the city council] has been a real positive. We have brought along other interested bodies that want to be involved with the process of governing. You can see the snowball effect that has come about.” A researcher we interviewed agreed that expanding decision making to include community voices is key to effecting change and increasing equity, saying, “The real thing is a group of people who weren’t making decisions together before, making decisions together now.”

Although structural, systemic, and policy barriers continue to exist, findings about the broader context also reveal positive aspects about community strengths and evolving demographics that reinforce the progress of Community-Centered Health. The partnerships’ achievements in the face of barriers demonstrate an ability and growing adeptness to respond to and work around contextual difficulties. Building capacities to make progress despite barriers bodes well for creating lasting change, discussed in the next chapter.

5 Moving Toward Lasting Change

At five years into the initiative, Community-Centered Health partnerships are steadily making progress toward enduring outcomes, such as improvements in health across the community; durable policy, systems, and environmental changes at local, regional, and/or state levels; institutional transformations; and diversified funding to continue to support the partnerships' priorities.

Lasting Change and Enduring Outcomes

Examples from Cohort 1 partnerships demonstrate how community-based collaboratives can achieve visible and durable change, even within five years' time. Exhibit 12 summarizes the types of policy, systems, and environmental changes that each partnership has experienced along with associated health outcomes. It is followed by detailed findings showing progress toward all three Community-Centered Health goals and enduring ripple effects. Note that while partners attributed the changes noted below to the work of the Community-Centered Health partnerships, a wide range of factors contribute to policy decisions, systems and environmental changes, and improvements in health. The changes described here represent positive developments to which Community-Centered Health clearly contributed but may not have solely driven.

Exhibit 12. Summary of Cohort 1 Progress Toward Enduring Outcomes

Area of Progress	Collaborative Cottage Grove	Healthier Highland	Mothering Asheville
Upstream changes in policy, systems, and environment	• The partnership's focus on the lasting impacts of Cottage Grove's location atop a landfill has prompted state efforts to remediate the landfill, local creek, and park. • The partnership successfully remediated close to 200 units of housing, improving conditions for people with asthma.	• Key partners recognize their capacity to improve upstream health factors, such as a health care provider now operating a food enterprise and working on affordable housing. • Partners' actions are improving the environment, including creating access to healthy food in a community experiencing food apartheid and better paying jobs for health care workers.	• Partners have expanded their priorities and interests, going beyond reducing infant mortality to supporting families to thrive. New areas of focus, such as housing, reflect community priorities. • The partnership has achieved changes in policy and services that support equity, including greater access to legal services for residents, culturally appropriate care, and health system policies that explicitly recognize racism.
Health outcomes	• Partners have seen decreased emergency department use and increased access to health screenings.	• The partnership saw promising clinical indicators of diabetes and cardiovascular health prior to COVID.	• The partnership has made strides in providing access to doula care and improving infant and maternal outcomes for African American women.

Upstream changes in policy, systems, and environment

Partnerships have broadened attitudes and actions toward upstream shifts in health determinants and equity. Such changes awaken health care organizations and government policymakers to their influence on environmental factors that affect health, such as housing, community safety, fair wages, and access to healthy food.

Collaborative Cottage Grove

- **The partnership's focus on the lasting impacts of Cottage Grove's location on top of a landfill has prompted state efforts to remediate the landfill, local creek, and park.** A partner explained,

  > *"It wasn't uncommon for African American communities or low-income communities to be the site for the city dump and Cottage Grove is no different. It's about understanding that when you're already in a vulnerable position and then something compounds that it's no wonder there is a disparate impact. We started looking at those compounding factors and bringing more attention to the issues regarding the landfill. Because of a grant awarded to [two of] our partners, we've been working with the state's Department of Environmental Quality on remediation plans."*

- **As of Spring 2021, the partnership successfully remediated close to 200 units of housing, improving conditions for people with asthma.** Half of the remediated units housed children with asthma. In addition, a partner described efforts to raise residents' awareness of their housing and disability rights, saying, "We are very good at advocating for justice—social justice, racial justice, environmental justice—because we feel like that's the right thing to do. We've made great strides with that, making sure that people know their rights with their landlords if they have some type of disability because sometimes people are not treated fairly when they have a disability when it comes to housing or anything else."

  A researcher from the broader field of community change concurred that social justice advocacy is a strategy that can effectively support an effort like housing improvement over the long term, "Some of the communities [I work with] are talking about housing justice and wanting to improve housing," they said. "They've been doing a lot of policy advocacy. When you can get political and public will behind the work that you're doing, that can really help sustain and scale the change."

Healthier Highland

- **Key partner institutions now recognize their capacity to improve upstream health factors.** Since "operating a food enterprise and getting ready to build affordable housing", a clinical partner now holds a broader view of health care, saying, "It's the most rewarding thing I've ever been a part of." A city representative demonstrated a similar shift in mindset, saying, "If people don't have a safe house and a safe community, they can't think about their health. You have to have those things first. I realized we're on the front lines of this. If we don't do our job well, none of this other stuff matters." A city council member echoed, "When we don't have good housing, a safe place to live, and proper lighting, we live in fear. All those things play an important part of not just our body being healthy, but our mental health state."

Photo Credit: Healthier Highland Facebook

- **Partners' actions are making visible improvements to the health environment.** Notable changes include:

- **Access to healthier, affordable food.** The partnership launched RAMS Kitchen, which stands for Really Amazing Meals with Soul, to provide healthy, low-cost meals in a restaurant setting. RAMS Kitchen, one partner remarked, "is just phenomenal for our community and for Gastonia. Our community is full of convenience stores and no good food. We actually brought that to the community. That is the greatest achievement hands down." Another partner added, "We have partnerships with community gardens, so community members have access to free vegetables."

"I'm very proud that, especially during COVID, we have successfully opened up a food enterprise in our community. We have a full-fledged restaurant to improve access to healthier food options at an affordable price."

– Healthier Highland partner

- **Safer living conditions.** A city department director detailed, "We've done a number of projects. All the streetlights we replaced with LED lighting. We've done sidewalk connections and high visibility crosswalks, we've built houses. Just my department in the city has invested around $3 million in the community over the past five years for these projects."
- **Higher wages for safety net health care workers at the bottom end of the pay scale.** As a partner explained, "When Joe Biden was handing out COVID relief money to Federally Qualified Health Centers, we got over $15 million. We invested the majority of it back into our workforce. For our CEO this would not have been number one on his list if we hadn't done Community-Centered Health. We're paying $15 an hour as our lowest wage, trying to bring about equity. We're a nonprofit, but we pay more than our hospital does now. That came about as a result of this work. We're getting close to 800 employees, so that's impacting a lot of lives."

Mothering Asheville

- **Partners have expanded their priorities and interests to include upstream health factors.** One partner involved in Mothering Asheville noted, "Our plan went from being just about birthing people and infant mortality, to Black families thriving. For example, housing is now a priority." Indeed, housing planning is actively moving forward. As another partner explained,

  "Mothering Asheville and [others] are working on a housing strategic plan to help women have a safe place to go home after they deliver, and for Black families to have a safe place to go. We are working with some families who are homeless or do not have an adequate place to stay. This community is really digging deep and figuring out the causes of these issues, ways that people need to be supported, and policies that need to change."

  A third partner lauded Mothering Asheville's partners for "the shared interest now in the policy decisions—there's just a new level of awareness, excitement, and energy."

- **The partnership has achieved changes in policy and services that support an equitable health environment.** Some of these include:
  - **Improved access to legal services.** "[One partner] who's our safety net legal services provider in the region has been key in establishing a medical-legal partnership," a partner reported. "Buncombe County also has a referral contract with Pisgah Legal, which has been very important around eviction services. This legal service provider has been key to redressing economic barriers that result in poor birth and health outcomes."
  - **Improved county infrastructure for culturally and linguistically appropriate health services.** As a county representative and Mothering Asheville partner stated, "Our emphasis on equity has helped accelerate, from a public health side, culturally and linguistically appropriate services. Language justice has gone through the roof—it's a formalized department in our Health and Human Services Division."

- **County health policies recognizing racism.** A partner remarked,

  > *"Mothering Asheville—the members collectively and individually—have continued to make sure that analysis of racism and white supremacy have been part of the public health conversation in this county. A vision for what racial justice looks like in birth and prenatal postpartum outcomes for Black women in this community—that was not a space that had power and voice and leadership before all this started, and it's now embedded in our county's community health improvement plan."*

  In addition, another partner asserted, "Mothering Asheville was one of the key contributors to us making policy history for the county. In 2020, the Buncombe County Health and Human Services Board and our county commissioners passed a resolution that racism is a public health and public safety crisis. That policy milestone has been really catalytic."

Photo Credit: Mothering Asheville Facebook

- **A hospital allowing doulas during COVID.** A partner explained, "For a while, doulas were not allowed in the delivery room at the beginning of COVID-19. A lot of advocacy through Mothering Asheville and SC4S said they are a part of the medical profession; they do need to be in the room. So locally there was a policy change to allow doulas into the delivery room."

Health outcomes

Early signals suggest positive effects of Community-Centered Health partnerships' work on the health of community members. As is the case with other similar health collaboratives, tracking health outcomes within Community-Centered Health is difficult. This is due to a range of factors, including limited data sharing by clinical partners, challenges of tracking changes within a given community, and the time needed for measurable health effects to show up in a population after changes to policy, environment, and systems take place. However, each of the Community-Centered Health partnerships have shown indicators of progress toward health outcomes, as described below.

Collaborative Cottage Grove

- Partners highlighted health outcomes including **decreased emergency department use**, as well as **increased access to health screenings** at health fairs, where even uninsured people can receive screenings for diabetes, high cholesterol, HIV, and sickle-cell disease, among others. "That was one way we could lessen the disparity within health," noted a partner.

Healthier Highland

- One partner spoke of **promising clinical indicators of diabetes and cardiovascular health**, commenting, "COVID caused a huge upset in us being able to carry out our programs with person-to-person contact. But we were beginning to see positive trends as it relates to blood pressure and A1Cs among our patients."

Mothering Asheville

- The partnership has made strides in providing **access to doula care**, supporting healthy birth outcomes. One partner reported, "Birth outcomes and moms that we've been able to support--us being there has made such a

difference. There were 121 births during COVID. We were able to support 64."

- SC4S is now one of the only doula programs in North Carolina piloting with three of the Medicaid primary health providers for **doula reimbursement services**. One partner shared, "The disparity numbers are decreasing. Insurance is starting to accept doulas as a part of people's insurance plans, which is really important. People have access to more care."

Ripple Effects: How Community-Centered Health Influence Spreads

Cohort 1 partnerships have benefited communities in unanticipated ways and have shown others what is possible. The following findings illustrate how the Community-Centered Health work has made a broader difference.

- **Community-Centered Health ideas and practices are spreading to nearby communities**. In one community, a clinical partner reported borrowing successful strategies to apply in other locations where they work. "My work is in three different counties," they explained. "I take best practices and things we've done, taking that same community health worker approach and human-centered design approach. I'm implementing it [in clinic settings in other communities], so we're really talking about a clinical shift. I've brought [community partners] in as subject matter experts, [for example on] starting community gardens or [using] community health workers."

  At the same time, some partners cautioned that communities do not always understand the level of effort they must put in to drive community-led change. As a city government partner in another community put it, "Other communities want improvement too. We're willing to do that, but you have to put in some legwork too. I don't think people realize how much work these residents have put in."

"This is the opportunity for us to reframe, rethink, and reimagine our work. If you don't have a broader lens and partnerships where you can pivot in the midst of a disaster, you're going to be struggling."

– Collaborative Cottage Grove partner

Photo Credit: Collaborative Cottage Grove Facebook

- Healthier Highland's **work has added shine to the reputation of the Highland neighborhood.** Improvements to housing and city streets are not the only components that have piqued neighboring communities' interest in Community-Centered Health. RAMS Kitchen has also served to build community with those outside the neighborhood. One Healthier Highland partner commented, "I'm very pleased to see the diversity of people who support RAMS Kitchen. We now have people who didn't know about our community [or] had misconceptions about it coming in and learning what we've known all along—that it's no different from any other community. You talk about community activation, community building, community empowerment. It may not seem like much, but it means a lot to those of us who are working and living in this community."

- **Across all partnerships, partners have expanded their capacities and are garnering attention and funding from state and national sources.** A researcher not associated with Community-Centered Health pointed to the ability of partnerships to come together around fundraising as key to sustainability, noting "This work is going to take a really long time, so you need somebody who wants to do it and is in for the long haul, and you need money to keep doing it. Continuing to get grant funding is great, but not necessarily tenable long-term. Additional funding certainly does help and propels work to go further." The Cohort 1 partnerships have made connections to bring in funded efforts to address community priorities and have gained attention from local, state, and national media, including numerous news and journal

"Some of the smaller organizations are building capacity and now [one] is applying for 501(c)(3) status so they can go after federal grants. That's the process of sustainability. If they've built up a structure so they can keep going under their nonprofit, that's a tremendous outcome."

– Collaborative Cottage Grove partner

articles citing the partnerships' work (see Appendix C).

In one Community-Centered Health example, Mothering Asheville's role in launching a new entity has led to further connections and actions to address housing needs. A partner shared how the partnership is currently building connections with new organizations, both locally and nationally, that bring affordable housing experience and expertise into Asheville. They are also thinking ahead about ways to potentially fund this effort, should it come to fruition.

Collaborative Cottage Grove, by sharing data and a compelling story at a time when systemic racism awareness has grown, managed to secure a difficult-to-get site visit by a state agency. According to a partner,

> *"One huge accomplishment [happened] because the pandemic heightened deep-rooted, systemic issues related to race and environmental racism. The state's Department of Environmental Quality actually came out to do a site visit—which they never do—at the community's request. They came for us because they'd been engaged with us for a minute and the data that we've been sharing got their attention. That was a huge success and we're keeping those conversations going."*

Photo Credit: North Carolina Health News

Healthier Highland has successfully brought more federal funding for housing into not only Gastonia, but a three-county region. A partner explained,

> *"We'd never partnered with city government before and now that's one of our strongest partners. The [U.S. Department of Housing and Urban Development] Continuum of Care [program] is the way HUD gets federal money into communities. My little agency took it over because of our partnership with the city. Now we're getting ready to hire our third and fourth staff persons for the Continuum of Care. We've brought a whole bunch of HUD money into the community. We've found agencies from three counties that have now applied and received funding. We're working on strengthening the referral processes and our coordinated entry, our care management for people who are experiencing homelessness and people who are newly housed. All of that is coming about from doing this [Community-Centered Health] work."*

These instances of lasting achievements and spreading the influence of the Community-Centered Health partnerships portray strategies that each site has taken to pursue and embed meaningful changes. They also show how a concerted effort to make upstream changes can have a broad impact, including garnering attention and further funding. While each community must pursue enduring changes in the specific ways that fits its needs, the Community-Centered Health Cohort 1 examples demonstrate that durable outcomes and ripple effects are well within the scope of clinical-community collaborative work.

Reflecting on 2020 and Beyond

COVID-19 and **pervasive police violence** brought to the forefront by the murders of George Floyd, Breonna Taylor, and many others posed significant challenges to each of the Community-Centered Health partnerships, and the U.S. broadly. These events have spotlighted and exacerbated existing racial inequities due to a range of factors that systematically place certain groups at increased risk of illness and death, including discrimination in health care, overrepresentation in essential worker settings, and economic disinvestment.[a] For example, Black communities have experienced disproportionately higher rates of illness and death due to COVID-19. Similarly, data show that the burden of fatal police violence disproportionately impacts people of color, with Blacks experiencing the highest death rate at the hands of police.[b,c]

Reflecting on 2020, Community-Centered Health partners described how these events impeded progress. However, partners also reflected that these events created unique windows of opportunity, allowing partnerships to demonstrate both resilience and ingenuity in advancing their work.

Barriers to Progress	Windows of Opportunity
Prioritizing COVID limited clinical, hospital and public health partners' ability to engage in other Community-Centered Health efforts. As one partner noted, "COVID upended their work." The sole focus for many of these partners became responding to COVID-related illness and, more recently, supporting equitable vaccine distribution and vaccine education.	**The pandemic motivated partners to break down silos and strengthen supports for communities.** COVID sparked an uptick in partners' drive to help communities in need. Additional support has taken the form of increased and targeted COVID testing, protective equipment drives, direct food assistance, and housing supports. A partner in **Healthier Highland** described how partners also considered a broader community approach, "There are other neighborhoods just like Highland that aren't part of Community-Centered Health and they need access and services, too. So, we became more and more engaged and are looking at how we can spread the Community-Centered Health model to other neighborhoods we serve."
The shift to a virtual-only environment challenged community engagement. Moving everything online directly impacted residents with limited access to broadband Internet or technology, as well as senior citizens. Partners also reflected on the importance of in-person gatherings where "relationships were built over breaking bread with each other."	**Pivoting to a virtual environment built the capacity for partners and residents to navigate the virtual world.** For residents, this looks like building new skills to log into a Zoom call and effectively participate. For partners, it includes "build[ing] a new kind of [online] organizing muscle." As one **Mothering Asheville** partner commented, "Everybody has jumped in times 10 because of COVID. Our meetings have always been incredibly dynamic, but the leaders of Mothering Asheville have done a good job of ensuring that they're dynamic through Zoom." A partner also noted seeing more meeting participation at times, given the flexibility of the virtual setting.
Deeply rooted and systemic racism continues to directly, and disproportionately, impact the Community-Centered Health communities. While COVID heightened the level of crises that communities and residents are experiencing on multiple levels, as one partner noted, "we've [had] a crisis, and it is racism in this community."	**The racial reckoning that emerged in 2020 is creating space for powerful dialogue and learning, and more importantly, leading to concrete actions within Community-Centered Health communities.** In **Cottage Grove**, partners and state government are coming together to address the legacy of environmental racism in a local park. For Mothering Asheville, policy advocacy during the height of COVID means that Black mothers now have access to doulas during birth. Medicaid reimbursement for doulas is now being piloted. For Healthier Highland, city government is taking a stronger stance on diversity, equity, and inclusion by hiring a DEI director; and requiring staff to be appropriately trained.

a. Centers for Disease Control and Prevention. (November 2021). Health Equity Considerations & Racial and Ethnic Minority Groups. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html. Accessed December 7, 2021.
b. Tucker, W. (April 2020). *COVID-19 and Race in North Carolina*. NC Child. Retrieved from https://nCommunity-Centered Healthild.org/covid-19-and-race/. Accessed December 7, 2021
c. GBD 2019 Police Violence US Subnational Collaborators. (2021). *Fatal police violence by race and state in the USA, 1980–2019: a network meta-regression*. The Lancet, 398(10307), 1239-1255.

6 What Have We Learned?

Reflecting on the many community-specific examples and cross-cutting themes from Community-Centered Health Cohort 1 partnerships, lessons emerge for similar initiatives. This chapter distills those lessons, first providing general lessons for funders and other communities, and then offering considerations specific to the Blue Cross and Blue Shield of North Carolina Foundation.

What We Can Learn from Community-Centered Health

Above all, the Cohort 1 experience with Community-Centered Health shows that **building the power of community members and cultivating community-led decisions can transform the relationship between institutions and the communities they serve.** In all three partnerships, clinical and government partners shifted their mindsets and practices to connect and respond to community, and these shifts have paid off. Notably:

- Authentic efforts by institutional leaders have **built trust with communities** where distrust was the long-standing norm. Partners observed that community buy-in of government or clinical efforts comes more readily when community members are at the table. Also, as community members' voices are given weight in decisions about how resources are spent, they in turn show a new level of personal investment in their communities.
- Results show **progress toward equity** as evidenced by more diverse representation in decision-making bodies; greater access to health services including doula care and COVID preventive measures; increased institutional action to improve upstream health factors like housing, affordable healthy food, and neighborhood safety; and new policies that support equity and call out racism as a factor in health disparities.

The experience of Community-Centered Health Cohort 1 grantees also reveals **five important lessons** for funders and community partners about how to achieve this success:

- **Lesson 1: Understand and intentionally respond to the influence of historic factors and broader context, being explicit about addressing structural racism.** Context matters when implementing community-driven initiatives that explicitly focus on long-term policy, systems, and environmental change because the status quo is a product of that context. The Community-Centered Health experience affirms that acknowledgement of systemic racism, as well as knowledge of other political and systemic contributors to mistrust and

What Does it Take to Measure Change?

Researchers and other funders across the field grapple with questions related to operationalizing and measuring the progress of collaborative initiatives. Echoing others we interviewed, one researcher asked, "How do you measure community power or racial sensitivities or segregation or that kind of systems change? It's one area that needs particular attention." Another added,

> *"We're planting the seed today for the tree 20 years from now. Politicians and health care organizations don't operate on 20-year cycles. Is there room to develop new ways of monitoring progress and even anticipating progress? What are the interim factors?"*

At this stage inn Community-Centered Health, the clearest signs of progress are that institutions with influence on community health are changing their mindsets, and that organizations are actively working with and for community members in new ways. They are encouraging signs, indeed, yet the health and equity outcomes for these communities in 10—or 20—more years rests on the staying power of these changes and on other factors that are, at best, difficult to predict.

disparities, is a necessary first step to inform which actions will be effective to build trust and address upstream health factors. Reflecting on the evolution in their thinking, one Foundation staff noted "There's a spectrum there of naming and acknowledging [structural racism], and of where we start the work. We didn't name it in the first cohort very clearly, and almost two years in, they said, 'We can't seem to make progress.' Because we're not talking about the real issue." For other communities interested in doing this work, addressing systemic racism requires more than acknowledging and naming systemic barriers. It also requires actively working to shift the status quo. Community-Centered Health grantees highlighted the Foundation's shift toward action, for example, by providing a series of racial equity trainings to all partners. Grantees noted this training helped encourage them to be more explicit about equity in their own work as well. As one grantee remarked, "I've definitely seen a shift in the focus of the Foundation… they've made a really intentional approach in having equity as a strategic part of the Community-Centered Health work."

- **Lesson 2: Ensure that partnerships are committed to building trust and equity with community members and valuing the experience of residents.** A range of ingredients for success have emerged when it comes to community-centered initiatives. Partnerships form around shared goals, but each partner's idea of roles and responsibilities may differ. For cross-sector partnerships that center community to be most effective, partners must be prepared to move from practices of informing or consulting with residents to collaborating and deferring to residents to drive solutions. Beyond an openness to centering community, this type of collaboration requires partners to work differently. Examples of what this looks like include building adequate time for engagement that meets residents where they are, operating with transparency, celebrating small wins, and acknowledging missteps that may occur along the way. Community members hold essential experience and knowledge of what is needed and what works in their community and must be *valued as experts*. A *commitment to racial equity* acts as a through-line to encourage representative voices and actions that acknowledge contextual factors. Finally, a number of key practices will support a partnership's success, including clear, routine *communications* and *data sharing agreements*.

"Blue Cross has been unlike any other funder I've ever dealt with. I value the personal relationships that I've been able to establish with pretty much everyone that I've come into contact with there. The transparency, honesty, and trust they have exemplified as a funder is something that they should be commended for and should be a lesson to all funders."

– Cohort 1 Partner

- **Lesson 3: Take the time to develop strong partnerships and build necessary infrastructure, which are critical to long-term and sustainable change.** Building trust does not happen overnight. Partnerships need multi-year support to solidify and build their capacity as a collaborative body before they can pursue fundraising beyond an initial grant source. They also need non-monetary supports, including training, coaching, and technical assistance to address needs like building collaborative capacity, developing leadership, making evidence-based course corrections, and centering community. The investment timespan required for community-driven work to flourish also requires funders and partners to think differently about ways to measure success. For example, the formation of a coalition reflecting a diversity of community perspectives is one way to understand progress towards longer-term goals and outcomes. Funders benefit from recognizing that the sustainability of an initiative relies in part on whether the amount and timespan of grant funding and non-monetary assistance has adequately prepared a partnership for independence.

- **Lesson 4: Embrace flexibility to address emergent needs in uncertain times and set realistic expectations while continuing to track progress toward long-term goals.** Funder flexibility is important in addressing needs and issues that inevitably arise during the course of a multi-year effort, such as—in the case of Community-Centered Health Cohort 1—an emergent focus on equity and community power-building. The COVID-19 pandemic has made uncertainty the norm, and the concurrent widespread attention to racial equity spurred many Community-Centered Health partner organizations to articulate their commitment more vocally to addressing racism as a public health issue. Partners voiced appreciation for the Foundation's demonstration of living its values-listening and responding to the needs identified by community-based grantees, bringing an interest in discovery rather than predetermined solutions, and providing flexibility of funding and grant activities in the face of shifting conditions. Foundation staff emphasized their willingness to take a flexible approach as well. They highlighted the importance of centering

grantees' long-term initiative goals without requiring rigid measurements of success given the emergent, community-driven nature of the work. Based upon guidance from grantees, partners, and the Foundation, the Impact Framework is intentionally broad, emphasizing common elements and outcomes while also recognizing that this type of work can, and likely will, change over time. For other initiatives, the needs that emerge, by definition, cannot be anticipated. But funders and community partners can prepare to expect the unexpected by routinely reflecting and discussing how to adapt to the latest conditions to best serve communities. An ability to be flexible in and of itself is an important strength for lasting partnerships.

- **Lesson 5: Scale or sustain community-driven initiatives with investment from multiple sources.** Plan for diverse multi-year funding to support scaling and sustainability once initial implementation and partnership development are underway. Partnerships need time and support to become established enough to expand and diversify their funding. With strong relationships in place, cross-sector collaborations that include government and institutions (for example in health care, education, or the corporate sector) are helpful in leveraging funding that these partners can access or influence. Clear successes of Community-Centered Health have included securing city and clinical expenditures that met community-identified upstream health needs. Grant-supported successes can also provide a track record to attract funding from state, federal, or other foundation sources. The original funder can support grantees in pursuing such avenues by articulating funding diversification as a goal and providing capacity-building training to support grantees in achieving that goal.

Specific Considerations for the Blue Cross Blue Shield of North Carolina Foundation

Overall, grantees and partners shared deep appreciation for the Foundation's flexible funding approach, its ongoing commitment to equity, and its leadership in shifting the narrative in health care by centering community. Cohort 1 grantees were grateful for the two-year grant extension and offered several considerations specific to how the Foundation can best support their work as it continues.

- **Create regular touchpoints with Foundation staff**. While grantees appreciated the Foundation's trust and willingness to let communities lead, they also desired more frequent touchpoints. One grantee shared that the Foundation's connection had waned as the focus turned to Cohort 2, noting, "To not have the ongoing, authentic, intentional engagement, and consistency and communication, you feel without support a little bit, because how does [the Foundation] know what I need if we're not even discussing [it with them]?" Grantees see engagement with Foundation staff as critical so that the Foundation 1) stays abreast of successes and challenges, 2) strategically connects grantees to learning and capacity-building opportunities, and 3) plays a supportive role in lifting up grantees' work and the policy, systems, and environmental changes they are working toward.
- **Clarify expectations for the next two years of Community-Centered Health**. Grantees also expressed a need for clarity of the expectations for the next two years of grant funding. This was particularly important to Mothering Asheville partners, who recently experienced a leadership transition. As one partner reflected, "A lot of that institutional and programmatic knowledge has gone on with our home team transition…If we're going to make the most of these two years, we absolutely need a real orientation to expectations."
- **Facilitate peer connections and ongoing learning.** Partners shared that convening and training opportunities within and across cohorts provide valuable space to learn, troubleshoot, and develop important relationships. As the work evolves, new partners and community members come on board. Grantees expressed interest in training opportunities that include organizational partners and community members, which can be particularly helpful when core leaders or partners transition away from the work. As one highlighted, "I always lift up the opportunities that the Foundation provides to us as team leads [and] extend those to our partners, to our community members…that they otherwise would have never been exposed to." Grantees requested trainings on racial equity, managing group dynamics, and engaging broader community representation.

Conclusion

Given the wide range of factors that influence individual health and well-being, no single solution is likely to be effective in achieving improvements in this area.[16],[17] Cross-sector collaborations and partnerships offer one promising approach to addressing the social determinants of health and health inequities, thus contributing to improvements in health and well-being. However, the impact of these efforts is often not seen for many years, given the complexity and long-term nature of this type of work. Our evaluation of the Community-Centered Health initiative benefitted from the ability to take stock of many years of work in the three Cohort 1 communities, adding to a growing body of evidence about the promise of this type of approach. We found that these communities made progress in several areas, including:

- **establishing common values and practices** to support the work (i.e., acknowledging structural racism, committing to a shared vision, and valuing community perspectives and input);
- **working towards goals and outcomes,** such as building the leadership capacity of community residents, shifting mindsets of clinical partners, and seeing policy and systems changes related to partnerships' goals; and
- **having ripple effects**, such as through Community-Centered Health work spreading to neighboring communities or partnerships leveraging additional funding sources to support their efforts.

Lessons from this work have relevance to the Blue Cross and Blue Shield of North Carolina Foundation, as well as other funder and communities interested in this type of approach, as highlighted in the previous section.

At the same time, this work has not been without its challenges, such as **resistance** by some partners to embracing community-led decision making, **limitations around data sharing** hampering efforts to track progress, and a **political and social context** that often worked in direct opposition of partnerships' goals. Through our data collection, partners emphasized that residents' and local organizations' persistence and commitment to shared action helped them to address some of these barriers and make progress towards their goals.

In sum, in this time of political divisiveness amid monumental global challenges, the Community-Centered Health initiative, with its focus on local collaborative efforts led by the community, offers hope. For this and other community-centered and community-driven initiatives, findings and lessons from Cohort 1 provide meaningful examples for how to achieve positive, informed change. As a partner from Collaborative Cottage Grove put it, "It can happen. It's hard work, but it is some of the most meaningful work, and when you're able to look back and just smile on the inside, that brings so much joy. You'll be better for it."

[16] Towe, V. L., Leviton, L., Chandra, A., Sloan, J. C., Tait, M., & Orleans, T. (2016). Cross-sector collaborations and partnerships: essential ingredients to help shape health and well-being. *Health Affairs*, 35(11), 1964-1969.
[17] Cross-Sector Partnerships Can Improve Health Outcomes. (n.d.) Retrieved February 27, 2022 from https://www.pewtrusts.org/en/research-and-analysis/articles/2020/06/15/cross-sector-partnerships-can-improve-health-outcomes.

Appendix A: Community-Centered Health Interview Participant List

We are grateful to the following Community-Centered health grantees and partners, Blue Cross and Blue Shield Foundation of North Carolina staff, and other researchers and evaluators in the field who made time to speak with us.

Cohort 1 Grantees and Partners

- Abigail Newton, Gaston County Department of Health & Human Services
- Amanda Murphy, Mountain Area Health Education Center (MAHEC) Ob/Gyn
- Charles Odom, Community Resident
- Cindy McMillan, MAHEC SistasCaring4Sistas
- Donna Elliott, Kintegra Health and HealthNet Gaston
- Donyel Barber, Kintegra Health
- Greg Borom, Children First/Communities in Schools of Buncombe County
- Jamilla Pinder, Cone Health
- Josie Williams, Greensboro Housing Coalition
- Kelley Hubbell, YWCA Asheville
- Maggie Adams, formerly with MAHEC
- Patricia Macfoy, New Hope Community Development
- Sel Mpang, Greensboro Housing Coalition
- Vincent Wong, City of Gastonia
- Zo Mpofu, Buncombe County Department of Health and Human Services

Research and Evaluation Partners

- Dora Hughes, George Washington University Milken Institute School of Public Health
- Janet Heinrich, George Washington University Milken Institute School of Public Health
- Jeremy Cantor, John Snow Institute
- Jo Carcedo, Episcopal Health Foundation
- Kim Glassman, Equal Measure
- Siobhan Costanzo, Equal Measure

Blue Cross and Blue Shield of North Carolina Foundation Staff

- Danielle Breslin, Vice President – Operations and Learning
- John Lumpkin, President
- Katie Eyes, Vice President – Program and Strategy
- Merry Davis, Director – Healthy Food
- Valerie Stewart, Director – Leadership

Appendix B: Summary of Community Collaborative-Focused Literature

As part of the process to develop and refine the Community-Centered Health Impact Framework, the evaluation team reviewed reports, white papers, and relevant articles. A subset of the relevant reports reviewed are summarized below.

1. Center for Community Health and Evaluation. Regional collaboration for health system transformation: An evaluation of Washington's Accountable Communities of Health. January 2019.
2. Desert Vista Consulting, Center for Outcomes Research and Education, AGD Consulting. CACHI: Building, Diversifying, Transforming Three-Year Interim Evaluation Brief (2017-2019). *Issue Brief.* February 2021.
3. Equal Measure, Spark Policy Institute and MPHI. Community Approaches to Systems Change: A Compendium of Practices, Reflections, and Findings. *The BUILD Health Challenge.* November 2019.
4. Funders Forum on Accountable Health. Developing a Framework To Measure the Health Equity Impact of Accountable Communities For Health. July 2020.
5. Fine, M. and Shultz Hafid, M. How Philanthropy Support Organizations Understand & Advance Community Power Building. *The TCC Group.* 2020.
6. Hughes, D. L., & Mann, C. (2020). Financing The Infrastructure Of Accountable Communities For Health Is Key To Long-Term Sustainability: A legal and policy review to identify potential funding streams specifically for Accountable Communities For Health infrastructure activities. Health Affairs, 39(4), 670-678.
7. Levi, J., Heinrich, J., Hughes, D., and Mittman, H. The Power of Multisector Partnerships to Improve Population Health: What We Are Learning About Accountable Communities for Health. *Funders Forum on Accountable Health.* March 2021.
8. Stachowiak, S., Lynn, J., & Akey, T. (2020). Finding the impact: methods for assessing the contribution of collective impact to systems and population change in a Multi-Site study. New Directions for Evaluation, 2020(165), 29-44.

Appendix C: Community-Centered Health in News and Media

A small subset of news stories, journal articles and evaluation resources are included below for each of the Community-Centered Health partnerships. While not comprehensive, the list provides a snapshot of the Community-Centered Health partnerships' influence and spread, both locally within North Carolina and broadly in national journals and news platforms.

Collaborative Cottage Grove

- 2021 Research: Critical Factors in Cross-Sector Health Partnerships: Charting a More Promising Future
- 2020 News Story: In a Greensboro Community, city park sits atop a toxic landfill
- 2020 Journal Article: Engaging the power of communities for better health. North Carolina medical journal, 81(3), 195-197.
- 2018 Case Study: Collaborative Cottage Grove – Case Study. George Washington University Funders Forum on Accountable Health.
- 2017 News Story: Cottage Grove Initiative – Coming together for change
- 2017 News Story: Addressing Asthma Hot Spots in Cottage Grove
- 2017 Blog: Cottage Grove Neighbors are Educating College Students
- 2017 Journal Article: Collaborating for community health. North Carolina medical journal, 78(4), 248-250.

Healthier Highland

- 2021 University News: Improving Health care Access and Outcomes
- 2021 Research: Highland Shows UP, Speaks UP, Steps UP Aligning Systems for Health: Community-led Collaboration Advancing Health Equity
- 2021 News Story: RAMS Kitchen to add wheels to bring Gastonia residents healthy food choices
- 2020 Community Profile: Highland Neighborhood: A Model of Shared Governance
- 2020 Research: 2020 Baseline Assessment of Gaston County's Community Food System
- 2019 News Story: Grant to support food access solutions in Highland
- Website: BUILD Health Challenge Grantee

Mothering Asheville

- 2022 Journal Article: The Power of Community in Addressing Infant Mortality Inequities, Journal of Public Health Management and Practice
- 2021 News Story: Sweeping legislation aims to combat Black maternal mortality
- 2021 Nonprofit Blog: My clients need post-partum Medicaid coverage - A doula & childbirth educator speaks out about the challenges facing Black moms and babies
- 2020 Research: Sistas Caring 4 Sistas: From Picnic Tables to Pioneers
- 2020 Journal Article: The Power of Connection, Trust, and Voice: Perinatal Support Through Community, North Carolina Medical Journal
- 2020 Research: Community-Based Maternal Support Services: The Role of Doulas and Community Health Workers in Medicaid
- 2019 News Story: The Secret to Saving the Lives of Black Mothers and Babies, Politico Magazine
- 2019 News Story: Sistas' Aim to Reduce Disparities in the Delivery Room