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RESEARCH ARTICLE

Cross-Sector Collaboration in the High-Poverty Setting: Qualitative Results from a Community-Based Diabetes Intervention

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Objective. To characterize the motivations of stakeholders from diverse sectors who engaged in cross-sector collaboration with an academic medical center.

Data Source. Primary qualitative data (2014–2015) were collected from 22 organizations involved in a cross-sector diabetes intervention on the South Side of Chicago.

Study Design. In-depth, semistructured interviews; participants included leaders from all stakeholder organization types (e.g., businesses, community development, faith-based) involved in the intervention.

Data Collection Methods. Data were transcribed verbatim from audio and video recordings. Analysis was conducted using the constant comparison method, derived from grounded theory.

Principal Findings. All stakeholders described collaboration as an opportunity to promote community health in vulnerable populations. Among diverse motivations across organization types, stakeholders described collaboration as an opportunity for: financial support, brand enhancement, access to specialized skills or knowledge, professional networking, and health care system involvement in community-based efforts. Based on our findings, we propose a framework for implementing a working knowledge of stakeholder motivations to facilitate effective cross-sector collaboration.

Conclusions. We identified several factors that motivated collaboration across diverse sectors with health care systems to promote health in a high-poverty, urban setting. Understanding these motivations will be foundational to optimizing meaningful cross-sector collaboration and improving diabetes outcomes in the nation's most vulnerable communities.

Key Words. Cross-sector collaboration, diabetes, community health promotion, intersectoral health, population health

Collaboration between health care and nonhealth care sectors is increasingly recognized as foundational to achieving meaningful gains in population health (Alper 2014; Mattessich and Rausch 2014; Kassler, Tomoyasu, and Conway 2015). In contrast to prior strategies, which focused heavily on the delivery of health care services, population health strategies focus on “the health of all people in a given geographic area,” and often force health care systems located in high-poverty settings to think critically about the broader determinants that affect their patient populations (Kassler, Tomoyasu, and Conway 2015). Consequently, population health strategies emphasize cross-sector collaboration to incorporate health promotion across many types of services (Kindig and Stoddart 2003). The World Health Organization describes cross-sector collaboration from an intersectoral action framework, defined as “actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector” (World Health Organization 2011).

Particularly among vulnerable populations at high risk for diabetes and related conditions, cross-sector strategies are necessary to address the many environmental, social, and behavioral determinants that influence diabetes outcomes (McGinnis, Williams-Russo, and Knickman 2002). The Robert Wood Johnson Foundation (RWJF) Commission describes cross-sector partnership as the bedrock of healthy communities and one of four key action areas for achieving health equity (Robert Wood Johnson Foundation 2017). A 2013 report by the RWJF Commission suggests that cross-sector partnerships are now emerging, especially in areas such as promoting a culture of health and wellness, access to health care, access to healthy foods, and opportunities for physical activity (Mattessich and Rausch 2013, 2014).

Despite these changes, there is a paucity of literature describing innovative collaborations between health care systems and non-health care sectors (e.g., food, housing) (Peek et al. 2014a; Steve et al. 2016). The health care system has traditionally engaged communities as a solitary organization, using a

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biomedical model that may not advance broader health promotion goals (Wade and Halligan 2004). As such, there is a need for best-practice templates to guide cross-sector collaboration between health care and non-health care organizations (Alley et al. 2016). Importantly, few studies have explored motivations across sectors to invest in collaborative efforts taking place in communities with high rates of concentrated poverty and residential segregation by race, which may present unique challenges to collaboration.

The aim of this study was to explore and characterize the key factors that motivated a diverse set of stakeholders to engage in cross-sector collaboration with an academic medical center-based diabetes program. This program, Improving Diabetes Care and Outcomes on the South Side of Chicago (also known as the South Side Diabetes Project [SSDP]), is a multilevel, cross-sector intervention designed to address the multiplicity of factors that drive diabetes disparities among racial minorities in a high-poverty region (Peek et al. 2012, 2014a,b; Chin et al. 2014). Established in 2009, the SSDP intervention has four key components: (1) patient education and empowerment, (2) health care provider training, (3) clinical quality improvement/health care systems change, and (4) cross-sector collaboration to support diabetes self-management in community settings. This study focuses on the fourth component of the intervention and uses qualitative data to explore motivations for cross-sector collaboration in the high-poverty setting.

METHODS

Population and Setting

The South Side of Chicago is a 95-square mile region containing approximately 900,000 residents, the majority of which identify as African American (61 percent) or Hispanic (27 percent) (U.S. Census Bureau 2014). A large proportion of residents (28 percent) live below the federal poverty level (U.S. Census Bureau 2014). Diabetes was targeted by this intervention because of its high prevalence in the region, estimated to affect nearly one-quarter of residents (Lindau 2013), and because of notable disparities in diabetes outcomes among racial minorities in Chicago (Feinglass et al. 2008; Goodney et al. 2013). South Side residents also identified diabetes as a priority health condition that was of particular importance to community members (University of Chicago Medicine 2014). The intervention was designed to be a sustainable program after the 5-year research evaluation period ended. As such, the implementation team introduced the intervention as the “South Side Diabetes

Project” (instead of the “South Side Diabetes Research Intervention”) to underscore a commitment to ongoing collaborative partnership with the community. In addition, the SSDP’s community-based activities were not limited to persons with diabetes, and they functioned to promote health more broadly within the community (Peek et al. 2012; Chin et al. 2014).

The broader SSDP intervention has been described more fully in previously published work (Peek et al. 2012, 2014b; Goddu et al. 2015; Oaklander 2016), but we highlight two examples of innovative, cross-sector strategies implemented between health care and non-health care sectors. In the FoodRx program, the SSDP collaborated with a farmer’s market, local grocers, and community-based pharmacies to implement a food prescription program that encouraged healthy and nutritious eating (Peek et al. 2014b; Goddu et al. 2015; Oaklander 2016). This program facilitated shared decision-making between patients and providers, provided point-of-purchase nutrition education at all locations where the FoodRx was accepted, and also addressed food insecurity by assigning a monetary value to each food prescription (Goddu et al. 2015). Another popular SSDP intervention was a point-of-purchase shopping tour at local grocery stores. Grocery store tours provided interactive and culturally tailored nutrition education delivered by racially concordant staff, and they took place in the patient’s own neighborhood context (Peek et al. 2014b). This intervention also addressed food insecurity by providing a monetary voucher for food purchases at the end of each tour (Peek et al. 2014b). These SSDP interventions required significant collaborative efforts (e.g., time, staff) and financial buy-in (e.g., pharmacies and grocery stores provided gift cards for food) from community partners; thus, it was important to understand each partner’s motivations for and commitment to participating in collaborative efforts. Although data collection is still ongoing for these efforts, early data support success of the intervention, especially for patient experience, patient skills and health behaviors, health system processes, and diabetes-related health outcomes (Peek et al. 2012, 2014b; Chin et al. 2014; Goddu et al. 2015).

Study Design and Analysis

We conducted in-depth, semistructured interviews with leaders from 22 key stakeholder (SH) organizations that collaborated with the SSDP. These included large businesses, small businesses, health advocacy groups, community development organizations, faith-based organizations, a government representative, public access/broadcasting services, and community-based health

partners, such as home health agencies or patient navigators (Table 1). Participants were recruited using a purposeful sampling approach to include representatives from all stakeholder organization types. Staff from the intervention contacted potential participants and arranged a time for recorded telephone or in-person interviews. Ultimately, every stakeholder organization with an ongoing collaboration with the SSDP was interviewed; no stakeholders declined participation.

Interviews were conducted by two interviewers (one interviewer per interview), who were unaffiliated with the intervention, using a semistructured topic guide. The topic guide included questions regarding the organization’s mission, target population, reasons for collaborating with the South Side Diabetes Project, types of projects initiated, quality of partnership, investment in partnership, concerns or challenges, and impact to the community. Subsequent iterations, informed by prior interviews, included additional topics regarding population health and returns on investment. The topic guide was designed using a broad range of open-ended questions to facilitate in-depth discussion and included follow-up probes to elicit detailed responses. Participants often deviated from interview topics and were encouraged to discuss their collaborative experiences freely. Thus, themes emerged from the

Table 1: Stakeholder Classification, South Side Diabetes Project, Chicago, IL

<i>N</i> = 22			
<i>Sector</i>	<i>Organizational Type</i>	<i>Examples</i>	<i>n</i>
Business	Corporation (>500 employees)	Grocery store, pharmacy	2
	Small business (<50 employees)	Fitness organization, food service organization	2
Community	Health advocacy group	Nongovernmental organization, health education organization	4
	Community development organization	Farmer’s market (food development), youth empowerment, economic development	3
	Faith-based organization	Place of worship, faith-based network	3
Government	Government partner	Elected official	1
Media	Public Broadcasting Services	Television network, health radio show	3
Health system	Community-based health partner	Home health agency, patient advocacy group, community health worker	4

Note: Examples reflect the Robert Wood Johnson Foundation (RWJF) commission key issue areas, including promoting a culture of health and wellness, access to health care, access to healthy foods, opportunities for physical activity, and Health Impact Assessments for community development projects.

interview content rather than interview topics. Interviews were audio or video recorded, lasted approximately 1 hour in duration, and were transcribed verbatim into Atlas.ti v.1.0.48 (for Mac) and v.7.5.12 (for Windows).

The research team consisted of six reviewers, including four physician researchers (E.T., M.P., M.C., and S.L.) and two public health researchers (K.G. and N.B.), all trained in qualitative research, and with cumulative experience in diabetes care, health disparities research, community engagement, and cross-sector collaboration. An initial codebook was developed after three investigators (E.T., K.G., and M.P.) inductively coded and discussed the first three transcripts using the constant comparative method, derived from grounded theory (Foley and Timonen 2015). Remaining reviewers then coded the same three transcripts based on preliminary concepts and categories. Using a standard of intercoder agreement, discrepancies were discussed, and the codebook was refined through an iterative process until core investigators agreed on all coding assignments. All transcripts were then randomly distributed among investigators and coded independently by two reviewers, with one primary reviewer (E.T.) who read and coded all 22 transcripts. The primary reviewer wrote reflexive and theoretical memos and corresponded with all other reviewers to discuss coding assignments and resolve discrepancies. During this process, the codebook was iteratively refined using constant comparison over successive interviews to fully extract recurrent themes across all interviews. The entire research group subsequently met to resolve any outstanding issues between coders. After all investigators reached consensus, the final selective coding structure was applied to all transcripts and entered into Atlas.ti 4.2 for data organization and retrieval. We performed basic thematic analysis using inductive methods based in grounded theory. The primary reviewer also developed an integrative transcript summary to assist in data analysis and refine relationships between themes during the analysis.

Of note, four members of the research team (M.P., M.C., K.G., and N.B.) were also core members of the South Side Diabetes Project, with significant familiarity with the stakeholders who were interviewed. The primary reviewer (E.T.) was selected for having no former ties to the stakeholders that were interviewed, aiming to provide a balanced perspective for data analysis.

This study was approved by the University of Chicago Institutional Review Board (IRB).

RESULTS

Participant Characteristics

We interviewed leaders from 22 key stakeholder organizations working in collaboration with the South Side Diabetes Project, representing five distinct sectors (business, community, government, media, and health system) and eight organization types (Table 1). All organization types were involved in addressing one or more of the aforementioned RWJF Commission key issue areas (Mattessich and Rausch 2013) and included businesses (e.g., grocery store, fitness organization), community development organizations (e.g., food bank, farmer's market), and community-based health partners (e.g., home health agency, patient advocacy group; Table 1).

Stakeholder Perspectives on Cross-Sector Collaboration in the High-Poverty Setting

Stakeholders reported that collaborations with the SSDP most frequently focused on providing culturally tailored and point-of-contact health education about diabetes prevention and control, improving access to and coordination of diabetes care, and providing material resources (e.g., food vouchers) to individuals and communities affected by diabetes. Overall, stakeholders described their collaboration with the SSDP as a highly positive experience. Participants endorsed very collegial and supportive working relationships and perceived the intervention as having a positive impact on the overall health of the community.

However, stakeholders did note several unique challenges to collaborating with the SSDP intervention. First, smaller organizations often described themselves as “barely scraping by” and functioning on insufficient financial resources. They often had an earnest desire to participate in collaborative efforts, but also practical limitations on their time, staffing, and finances:

SH2: I think that while there are all kinds of opportunities where we would love to say yes [to collaborative efforts] . . . we aren't always able to do so and I think that's just having small staff and limited time and limited financial resources are all challenges. Obviously, we have to find ways to work around that because those things don't change.

Stakeholders also noted that while their own finances were often limiting, they were additionally confronted by the financial limitations of the neighborhoods and people they served. One stakeholder described the challenge of

delivering health services and interventions in neighborhoods with a historical legacy of poverty:

SH8: The [neighborhood] area where I live and also serve . . . is a deprived area. [Many people] are not able to get to any of those types of [diabetes] services at all. [This neighborhood] was an area that [a government official] said . . . he would never put any money back in and it's been a decimated area for years.

Others described the challenge of cultural disconnect between health care interventions and the populations targeted:

SH14: The more people that understand the culture—I mean the South Side is very, very black—so if individuals don't understand the culture of it, it's kind of hard to touch certain people.

Stakeholder Motivations for Cross-Sector Collaboration

Despite these challenges, all stakeholders were motivated to collaborate and sustained their cross-sector partnerships with the SSDP intervention. We found six recurrent themes characterizing the key motivations for stakeholders to engage in cross-sector collaboration with the health care system: (1) to fulfill an organizational mission or goal, (2) to improve financing, (3) to enhance brand, (4) to access a specialized skill set or knowledge base, (5) to support professional networking, and (6) to increase health care system involvement in community-based efforts.

Theme 1: Organizational Alignment

All stakeholders ($n = 22$) described cross-sector collaboration as an opportunity to fulfill an organizational mission or goal (Table 2). Many community-based organizations (i.e., health advocacy groups, community development organizations, and faith-based organizations) described goals related to enhancing access to diabetes care, preventing diabetes in high-risk communities, and improving the lives of people affected by diabetes (Table 2, Section 1a). One stakeholder described the importance of broader health promotion in the community, beyond programs and services:

SH11: A healthy community does not just mean economics or housing or social programs. A healthy community means residents in the community are healthy and are knowing how to manage health issues.

Table 2: Stakeholder Motivations for Engagement in Cross-Sector Collaboration to Improve Diabetes Outcomes

1a. To fulfill an organizational mission or goal	<p>Health advocacy group (Stakeholder [SH] 2): “We take it very literally to do the things that we can to help to prevent the disease and to do things that we can to help to secure a cure. We are really passionate about improving the lives of all people affected by diabetes.”</p> <p>Faith-based organization (SH13): “So many people don’t take time to find out about their health . . . so we wanted people to be aware . . . just for anyone who didn’t know that they may have diabetes, that they find out and know what steps to take to find out.”</p> <p>Public broadcasting service (SH15): “Being an advocate for many people who cannot sometimes speak for themselves, I wanted to put different faces on it and then also provide information so people can learn to live with diabetes successfully.”</p> <p>Health advocacy group (SH3): “Diabetes, heart disease, obesity . . . all of these health issues are I think interrelated and we all have that common goal to just improve the overall quality of health for our communities.”</p>
1b. To address population-level health priorities	<p>Public broadcasting service (SH12): “Diabetes is something that . . . really affects African American community at large. So being that we do cater to an (African American community) . . . as I stated earlier, we are one of the most well known and also unique voices for the African American community . . . it just makes sense (to collaborate).”</p> <p>Government partner (SH11): “(We were) interested in the population that is identified as high risk as well as identifying individuals that we don’t know or they don’t know are high risk . . . and getting treatment and services for those that have been identified.”</p> <p>Corporation (SH5): “Our customers are historically predisposed to certain health issues . . . (they) are communities that are typically left without groceries, healthy options.”</p> <p>Community development organization (SH21): “The hospitals and health systems are increasingly interested in population health—and not just managing illnesses, but actually trying to make the population healthier, so we found that is a natural partnership and we have been building on that.”</p>
2a. To improve short-term financing	<p>Community-based health partner (SH17): “(We hoped to) pool resources because at times, you know, there may be limited resources so if we reach out to the same communities it’s great to be able to partner to pool those resources to be able to engage and educate the community.”</p> <p>Community development organization (SH19): “As a community based organization, any time we can tap into grant dollars to advance <i>our</i> health care initiatives, that would have been great . . . you know just tapping into more resources, more financial resources for our organization.”</p>

Continued

Table 2: *Continued*

	Community development organization (SH21): "Over time we came to realize private foundations are not going to fund it and (we) are public charities, not money makers . . . Part of our thinking in the past years has been how do we engage the health sector . . . especially now with the ACA, the Affordable Care Act . . . We are increasingly interested in health so we have reached out to the health sector, not just to the University but also now to other health partners and (we) are coming to the realization that this is a way not just of funding our (organization), which is important, it is also a model for (funding organizations) all across the country."
2b. To improve long-term financing	Corporation (SH22): "A long-term investment I think is to create loyal diabetic patients to us, that they come and get all of their diabetes needs from us. We don't want patients to go to multiple pharmacies. We want the pharmacist to have the complete profile for that patient so they can help that patient with all of their needs."
3. To enhance brand	Public broadcasting service (SH12): "One thing about (our organization) that I can say is that we have a very loyal listener base. So if we're pushing a product . . . our listeners are very loyal so when we have these organizations on and our audience hears them we're very credible with them, so it means a lot to them you know that they hear those organizations on our show and they know that they're supporting us." Corporation (SH5): "If they can learn (nutrition) while they're walking through our stores and they know that we are all in this partnership together, that's the value of what it means for us to be staked in that community, and the community knows that we have a vested interest in their health and wellbeing." Corporation (SH22): "(We wanted to) obviously increase awareness of our brand. Also, increase awareness in these communities that we have these food oasis stores and we are committed to diabetes . . . I think when we started this . . . we were trying to figure out how do we become partners with other organizations that are trying to address different health disparities within the city of Chicago, so just more of awareness that (our organization) wants to be involved in these type of projects. I think they see (us) as being a big organization and 'you are just here for profit,' but ultimately we are here for patient care and, yes, we are a for-profit organization, but we want to make sure that we are working with everyone within our communities if it is a federally qualified health center, a health system, or a physician . . ."
4. To access a specialized skill set or knowledge base	Community-based health partner (SH18): "There's such thing as good information and there's such thing as bad information . . . you want to try to get all the good information into the community . . . with this (health system partnership) you're getting precisely what you're supposed to be getting—the right information from the right people." Health advocacy group (SH2): "It's creating opportunities for people to talk to experts and to ask some of the difficult questions that laypeople or lay educators may not have the technical knowledge to answer. Creating opportunities in spaces to bring that kind of knowledge to the larger community, I think is helpful."

Continued

Table 2: *Continued*

5. To support professional networking	Public broadcasting service (SH15): “They’re very informative . . . even beyond the project itself we’re a continual resource of information and creating networking opportunities for each other.” Community development organization (SH21): “This (partnership) really enabled us to have a kind of access to the community that we otherwise can’t have. We go into DHS [Department of Human Services] offices. We go to all sorts of community events. We are in the schools. We reach out in many, many ways, but this is a whole different form of outreach that is exciting for us and very worthwhile . . . there are other opportunities for a partnership that we have already kind of taken advantage of, if you will, as a result of the initial partnership.”
6. To increase health care system involvement in community-based efforts	Faith-based organization (SH8): “North Lawndale is connected with many hospitals but from my eyesight they never come in . . . within their community in the area that they serve.” Public broadcasting service (SH15): “I do say the city of Chicago can be sometimes a little clique-ish, if you would . . . (but) I think more of a presence in churches (could strengthen the relationship).” Corporation (SH22): “We are talking to different partners across the United States of how we can be part of whatever population health mission they have. Partnering with different physician groups and hospital systems to be another piece of the pie because I think so many health care organizations work in silos.” Community development organization (SH10): “(We don’t) necessarily have to be at the forefront of leading every project or program . . . we can collaborate with other entities that can lead the project or program.”

Businesses also described collaboration with a health care system as an opportunity to fulfill their core mission of being a good corporate citizen:

SH5: At the beginning of the day, we’re . . . a business, right? But how do we serve our community is always something that is very near and dear to us, because we realize that you can’t just be a business in the community. How could it not be a good collaboration when you’re telling me that you are teaching people that are actually our customers how to live better and healthier lives?

Interestingly, many stakeholders ($n = 17$) described their organization’s mission as focused on more general population health priorities (Table 2, Section 1b), broadly defined as improving the health of communities at risk for poor outcomes. These priorities were articulated by all organizational types, but most notably among community-based health partners, a government stakeholder, large businesses, and health advocacy groups. Some stakeholders described the need to target racial and ethnic minority populations with a high burden of diabetes and poor access to diabetes resources (Table 2, Section 1b):

SH2: The prevalence of diabetes in the African American community is staggering ... the fact that so many African American communities that exist on the South Side are designated food deserts and don't have access to healthy food ... which [contributes to] major complications of diabetes.

Others described priorities based on diabetes risk; notably, the government stakeholder, an elected official, described the need to identify high-risk individuals (e.g., middle-aged persons) and neighborhoods, and target interventions based on risk profile and community need (Table 2, Section 1b).

Theme 2: Financial Support

Several stakeholders ($n = 8$), including those from advocacy groups, community development organizations, and community-based health partners (e.g., community health workers, diabetes educators), described limited immediate finances as a motivating factor for collaboration with health care systems (Table 2, Section 2a). One stakeholder expected that health care systems may have increased financial motivation to fund community-based programs (e.g., farmer's markets) based on shifts in health policy:

SH21: Especially now with the Affordable Care Act ... [We] are coming to the realization that [partnering with health care systems] is a way not just of funding our [organization], which is important, it is also a model for [funding organizations] all across the country.

In contrast, large business organizations ($n = 2$) in our sample provided financial assistance to fund community-based interventions (e.g., "prescriptions" for healthy food) (Table 2, Section 2b). These organizations were less interested in immediate financing (e.g., direct funding of programs) but described an aspiration for long-term financial gains related to a broader consumer base, customer loyalty, and opportunities to align with accountable care organizations (ACOs).

Theme 3: Brand Enhancement

Several organizations ($n = 7$), including large businesses and public broadcasting organizations, described partnership as an opportunity to enhance strategic branding. For most stakeholders, partnership helped organizations to brand themselves as promoting health and health care (Table 2, Section 3). For large businesses, partnership also enabled stakeholders to establish

rapport with the community and demonstrate that a for-profit business can be committed to the good health of its customers (Table 2, Section 3):

SH22: I think they see (us) as being a big organization and “you are just here for profit,” but ultimately we are here for patient care and . . . I think this kind of opened the door to show that, yes, (we) can be a trusted partner and (we) are not just here for-profit but (we are) here to actually be involved and address health disparities within the community.

Theme 4: Access to Specialized Knowledge and Skills

Across organizational types, stakeholders described collaboration as an opportunity to access and share the specialized knowledge of health care professionals (e.g., diabetes nutrition education) with the community (Table 2, Section 4):

SH19: (We wanted) to create spaces where, again, the experts could come out and they could talk about, you know, how much sugar content is in the basic things that we consume in our communities.

Community-based organizations were not only interested in disseminating information but were also interested in rectifying spurious normative beliefs about health in general, and diabetes in particular. One stakeholder alluded to the detrimental policies and practices (e.g., false advertising, misleading labels, etc.) that disproportionately promote poor lifestyle choices in low-income communities.

SH18: You want to try to get all the good information into the community because a lot of times our communities are lied to. We always get the wrong information.

For many community-based organizations, these types of educational opportunities represented an important exchange that could establish rapport and build trust between the community and health care system (Table 2, Section 4).

Theme 5: Professional Networking

Many stakeholder organizations ($n = 16$) indicated that the health care system served as a professional network node—an effective launching pad for connecting and collaborating with other community and health sector organizations (Table 2, Section 5).

SH17: They're pretty established and know quite a few community organizations, and they have a strong network, so it was an asset actually to be able to partner.

Theme 6: Health Care System Involvement in Community-Based Efforts

Finally, many organizations ($n = 13$) across sectors described the absence of substantive health care system involvement in ongoing community-organized projects (Table 2, Section 6), which has been a source of contention with and distrust of health care within the community. Partnership thus helped to make the health care sector more visible to the community sector.

SH8: [A South Side neighborhood] is connected with many hospitals but from my eyesight they never come in . . . within their community in the area that they serve.

Notably, one stakeholder described the burden of leadership as a community development organization, and articulated a desire for health care systems to share the responsibility of leading community health projects.

SH10: The one thing that we did not want to do was have them come in and then have to rely on my staff who are already at capacity to run another project . . . (We don't) have to be at the forefront of leading every project or program . . . we can collaborate with other entities that can lead the project or program . . .

DISCUSSION

Diabetes affects 30 million U.S. residents each year (Polonsky 2012; Centers for Disease Control and Prevention 2014), and its effective control must involve an array of sectors, including health care systems and non-health care entities (e.g., businesses, community-based organizations). Managing diabetes requires access to medical care, healthy foods, opportunities for physical activity, and health-promoting environmental conditions. However, programs and strategies to address diabetes often lack cross-sector approaches that respond to the complex, interrelated causes of diabetes-related morbidity, particularly within high-poverty communities (Peek et al. 2014a). This study provides insight into the motivations of diverse stakeholders who collaborated with an urban, academic health care system to address the multiplicity of factors that drive diabetes disparities.

Despite diverse interests and organizational types, we found that all stakeholders in our study wanted to align their goals to promote community health, particularly as related to diabetes. Stakeholders were interested in preventing diabetes in high-risk communities, increasing access to diabetes care, and improving the lives of people affected by diabetes. Even the large, for-profit businesses expressed interest in being “corporate citizens” and addressing health disparities in the communities they serve. Among unique motivations, five other themes emerged: financial support, brand enhancement, access to specialized skills or knowledge, professional networking, and health care system involvement in community-based efforts.

Community development and advocacy organizations described financial barriers to maintaining community-based programs and services (e.g., mobile food pantry, farmer’s market), and looked to health care system collaboration as an opportunity for financial support. Changes in health care financing, such as global payments and accountable care organizations, may now encourage health care systems to take a role in financing health promotion (e.g., diabetes prevention and control) strategies through cross-sector collaboration. Payers, such as the Centers for Medicare and Medicaid Services (CMS), may reward broader population-level initiatives to prevent diabetes incidence and complication rates (Kassler, Tomoyasu, and Conway 2015). In 2016, CMS established a 5-year demonstration program to investigate accountable health communities (AHC), a model of care designed specifically to test clinical–community collaborations and the impact of addressing social needs of a geographically defined population (Alley et al. 2016).

Additionally, the for-profit sector, particularly large businesses that profit from health-related activities, may be an overlooked opportunity for financing community health projects. Although partnership with the for-profit sector may pose reputation concerns or conflicts of interest (e.g., for-profit organizations may prioritize the financial gains of investors), there has been growing acceptance of public–private partnerships in public health since the 1980s (Johnston and Finegood 2015). In fact, the Center for Medicare and Medicaid Innovation (CMMI) included a sustainable business model requirement for funded Health Care Innovation Awards, indicating public–private partnerships as a prominent example of a sustainable model (Centers for Medicare & Medicaid Services 2012). This shift has been facilitated by a growing realism that financing is limited, and for-profit interests may not necessarily reflect conflicting interests. That is, business objectives may be inherently driven by a marketing or branding strategy to conjure public goodwill, but goals to improve health may still be aligned.

We also found that *social* returns on investment, such as professional networking benefits or spread of collaboration, were important among stakeholders. These network effects, facilitated by local opportunities for additional collaboration, may be critical for growing and sustaining health interventions. While professional networking was seen as an opportunity to enhance visibility and leadership, stakeholders also noted the importance of having reciprocal leadership (e.g., coleadership) from health care systems within communities. For example, one community development organization welcomed health care system involvement in community-based projects as a way of mitigating the leadership burden typically assumed by their organization. Recent literature has described the importance of having a “Community Quarterback,” a community-based organization already established as central to a given community, tasked with breaking down the traditional silos of health-related activity to foster collective, cross-sector impact (Erickson 2013). The stakeholders in our data generally regarded the South Side Diabetes Project (health care system) as Quarterback, and not unfavorably so, possibly indicating a need to share the responsibility of leadership between health care and community partners in high-poverty, resource-scarce settings. In reality, the ideal Community Quarterback may not be accessible in all settings. Indeed, other literature has called for leadership sharing across institutions, describing more collaborative leadership approaches (Lindau et al. 2011; Collins-Camargo et al. 2013).

We also found that some community stakeholders, before joining SSDP, were already involved in cross-sector collaborations to improve health. In their view, SSDP was joining *their* community-based efforts, rather than initiating a new effort. As such, health care systems may be approaching cross-sector collaboration from a discordant vantage point. Rather than asking, “How can community organizations be more involved in health care system approaches to population health?,” perhaps health care systems should be asking, “How can health care systems be more involved in community-based approaches already underway?” Stakeholders wanted health care systems to have a greater role in their community-based efforts—be it financial, social, educational, or organizational—and viewed collaboration as an opportunity for greater impact.

Key themes found across stakeholders provide a preliminary framework to guide planning for collaborative efforts and to optimize buy-in from non-health care sectors that collaborate with health care systems. Based on these findings, we propose a “Participate-Support-Partner” framework for aligning diverse stakeholders and engaging in meaningful cross-sector collaboration (Figure 1). *Participate* reflects the need for active involvement and participation

in the programs and interventions that are already taking place and consistent with collaborative goals. *Support* reflects the importance of addressing the underlying needs (e.g., social, financial) of stakeholders. Finally, *Partner* reflects the need to engage in shared leadership, planning, and sponsorship of activities, programs, and interventions, based on collaborators’ goals, unique assets, and capabilities (Figure 1). As described in our qualitative findings, not all collaborators will be prepared to *Partner* and may only seek *Support* in their own community-based efforts. Alternatively, other collaborators may expect to *Partner* and colead programs; challenges may arise if they are designated to *Support* or *Participate* roles. Understanding the intrinsic motivations for collaboration will help to clarify and optimize stakeholder alignment to promote health equity.

Figure 1: Collaborative Stakeholder Alignment to Promote Health

PARTICIPATE	SUPPORT	PARTNER
Engage in mutual participation in stakeholder activities, programs, and interventions	Engage in mutual support (e.g., social, financial) of stakeholder needs	Engage in shared leadership, planning, and sponsorship of activities, programs, and interventions
COLLABORATIVE STAKEHOLDER ALIGNMENT		
<p>Case Example: A community-based health advocacy group for elderly adults is motivated to collaborate because it is interested in increasing access to diabetes education.</p> <p>SSDP facilitates medical staff to attend community events and educate seniors on healthy eating, physical activity, and diabetes complications.</p> <p>A senior home provides residents with updates on SSDP events and programs.</p>	<p>Case Example: A corporation is motivated to collaborate because it is interested in brand enhancement (e.g., as a “good corporate citizen”).</p> <p>For-profit pharmacy provides monetary incentives to support a pharmacy-based food education program.</p> <p>SSDP identifies ways to ensure reasonable identification of the corporation’s brand (e.g., logo placement on handouts, banners at events).</p>	<p>Case Example: A community development organization is motivated to collaborate because it is interested in youth employment and hopes to leverage an intervention’s staffing needs as meaningful summer employment in the community.</p> <p>Community development organizations engage in planning the intervention.</p> <p>SSDP hires community youth to staff educational programs.</p>

There are several limitations to this study. We interviewed all organizations with an ongoing collaboration with the SSDP but focused on the one person from each organization who was the primary point of contact for collaborative efforts. These individuals were generally champions of the intervention within each organization and were thus the most capable of sharing insights on the collaboration itself. However, these individuals may have also been biased toward valuing collaborative efforts and may not have reflected the views of all leaders within their organization. Similarly, we did not interview any stakeholders who initially expressed interest in the SSDP but ultimately did not collaborate. This may have biased our sample toward organizations with a compatible mission or with higher capacity for collaborative work. Finally, this study examined stakeholders from a densely populated, high-poverty, urban region in the United States and may not be generalizable to other settings.

Cross-sector collaboration will undoubtedly play a role in emerging health care reform and population health management approaches to diabetes prevention and control. In an era when the cost of diabetes accounts for more than 20 percent of total health care spending (Bodenheimer, Chen, and Bennett 2009; American Diabetes Association 2013), more complex and multifaceted approaches are rapidly emerging. Understanding and addressing factors such as financial support for community-based health interventions, brand enhancement, and the role of health care systems in collaborative efforts may prove essential to enabling effective cross-sector collaboration. Such foundational work will be critical for improving diabetes outcomes in the nation's most vulnerable communities.

AUTHOR CONTRIBUTIONS

Respective author contributions are as follows. E. Tung and M. Peek carried out study concept and design. E. Tung, K. Gunter, N. Bergeron, and M. Peek performed acquisition of data. All authors were involved in analysis and interpretation of the data. E. Tung and M. Peek drafted the manuscript. All authors were involved in critical revision of the manuscript for important intellectual content. M. Peek, M. Chin, and S. Lindau obtained funding. M. Peek provided administrative, technical, or material support. All authors approved the final version to be published.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the supporting information tab for this article:

Appendix SA1: Author Matrix.