Successful Collaborations Between Local Government and Public Health: Exploring Multisector Partnerships to Improve Population Health

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Introduction

The state and local public health workforce plays a vital role in protecting and promoting the health of the people they serve, from providing life-saving vaccines and testing drinking water to responding to natural disasters and educating the public about the prevention of non-communicable disease. While the specific job functions and services that the public health workforce provides may differ from those offered by employees representing other business lines of the local government workforce (e.g., education, public safety, public works), these workforces share a common mission—to improve the lives of those in their jurisdictions and throughout the country through public service.

Meeting the complex public health challenges of the twenty-first century requires state and local public health agencies to not only attract, train, and retain a talented workforce, but to also develop an agile workforce that can engage in cross-sector collaboration with a variety of local government partners (e.g., transportation, education, public safety, public works), sharing strategies for success and lessons learned. Whether responding to wildfires, addressing gun violence, or working to curb the opioid epidemic, a coordinated approach among multiple agencies and sectors is needed. According to the findings of the Robert Wood Johnson Foundation (RWJF) Commission to Build a Healthier America, "creating healthy communities will require a broad range of players—urban planning, education, housing, transportation, public health, health care, nutrition and others—to work together routinely and understand each other's goals and skills."[1]

Cross-sector collaborations can look quite different from one another, depending on the partners, the topic of collaboration, and the nature of the collaboration, among other factors. When it comes to cross-sector collaborations, there is no one-size-fits-all approach. Thus, a landscape assessment is needed to better understand how state and local public health departments engage with other local government agencies: how organizations are collaborating, the barriers to successful partnerships, how outcomes of these partnerships are being measured, and opportunities for improvement.

Results from studies such as Mattessich and Rausch's survey of cross-sector collaborations provide valuable insights into how community and health organizations are partnering to improve population health.[2] As the nature of public health challenges evolves, it is critical to build upon this research by examining cross-sector collaborations and identifying models for success so that local government can not only respond to today's greatest public health challenges, but also anticipate and prepare for the future.

The purpose of this report is to explore how multiple local government agencies are collaborating to help address today's greatest public health challenges, with the ultimate goal of providing information and promising practices to elected and appointed leaders and public health officials who are considering engaging in (or are already engaged in) cross-sector collaborations. The report utilizes a mixed-methods approach, drawing on the results of a quantitative survey and qualitative case studies.

The first section of the report presents results of an online survey conducted by the Center for State and Local Government Excellence in collaboration with the International City/County Management Association (ICMA) focused on barriers and opportunities to general local governments working with state and local public health agencies. The second section of the report presents the findings of three case studies of successful local government cross-sector collaborations on healthy community design; safe, stable, affordable housing; and substance misuse/

prescription drug overdose based on the results of the survey. The report concludes with key takeaways on cross-sector collaborations to help state and local elected and appointed leaders, public health agencies, other local government agencies, and other stakeholders develop innovative collaborations to improve population health.

While this research was conducted prior to the emergence of the COVID-19 pandemic and the renewed focus on race and equity in the United States and police misconduct, the results are incredibly timely as state and local public health agencies partner with multiple local government agencies and departments to respond to these crises. Also, as states and localities focus on the recovery of public finances in the wake of the pandemic, these collaborative arrangements offer opportunities for future cost savings and increased efficiencies, while enhancing service offerings.

Section 1: Survey Results

The Center for State and Local Government Excellence collaborated with ICMA to conduct a survey examining barriers and opportunities to general local governments working with state and local public health agencies to address key public health challenges. It sought both general information on such collaborations as well as more detailed information about three specific programmatic areas: healthy community design; safe, stable, affordable housing; and substance misuse/prescription drug overdose.

The survey was pilot tested in July 2019 with ICMA regional directors and the ICMA editorial advisory board. It was then administered July 25 to August 29 to 3,100 ICMA members from jurisdictions serving populations of 10,000 or more. Surveys were sent to the chief administrative officer (CAO). The ICMA database was representative of the distribution of population size served by local governments overall from the 2012 U.S. Census of Governments numbers. A total of 287 respondents completed the survey, and respondents were diverse in terms of jurisdiction size and geographic location.
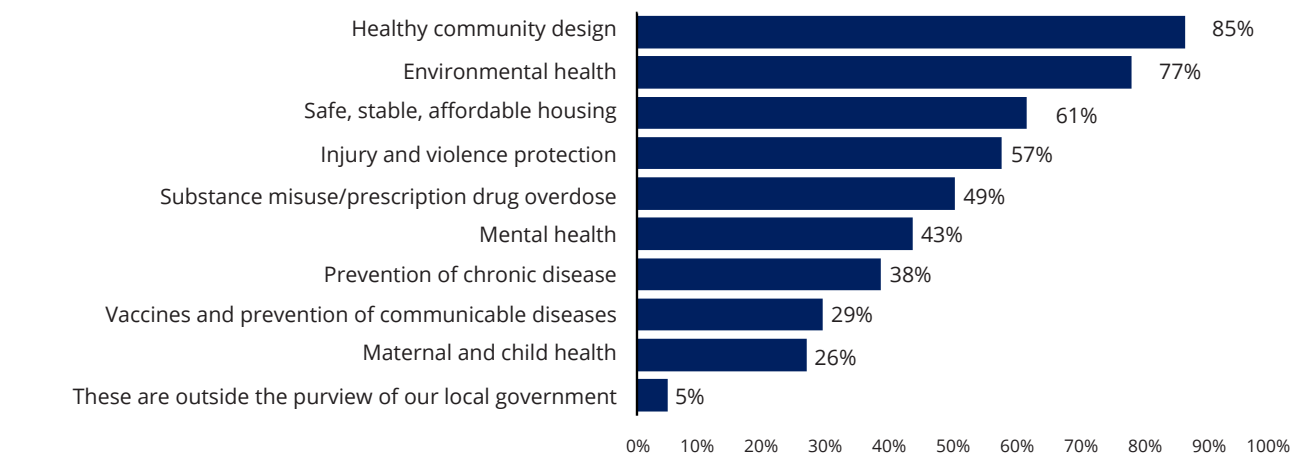
Overview on Collaborations

The first series of questions sought to better understand how local governments are collaborating in general to improve population health. Collaboration was defined as two or more entities who agree to share resources, such as finances, knowledge, and people, in pursuit of a common goal. The collaboration could be a one-time event, or occur on a recurring basis, and could be formal or informal in nature.

To understand where public health fits within their local government, jurisdictions were asked about the location of their public health unit. Nearly 3 in 4 respondents (72 percent) indicated that they did not have a public health unit internal to their organization, but rather, that public health is external to their organization (Figure 1). This may be an indication that a separate jurisdiction is responsible for public health (e.g., that it is administered by a county rather than a city), or potentially that the public health function is not part of the same chain of command.

Figure 1: *Organization of Public Health Unit (n = 287)*

- Internal public health unit
- Not internal public health unit
- No response
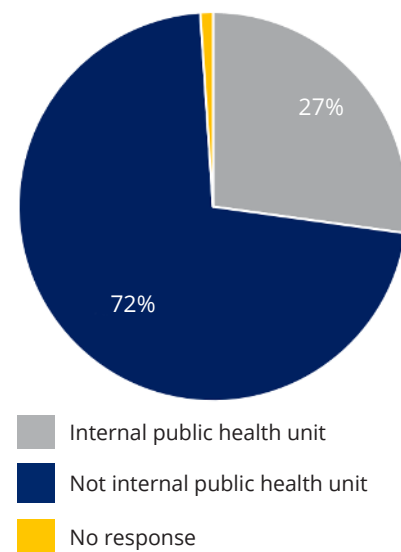
As the data in Figure 2 illustrate, not having an internal public health unit did not stop jurisdictions from actively working on a wide range of public health issues. Local governments were most likely to be actively working on the issues of healthy community design (85 percent); environmental health (77 percent); safe, stable, affordable housing (61 percent); and injury
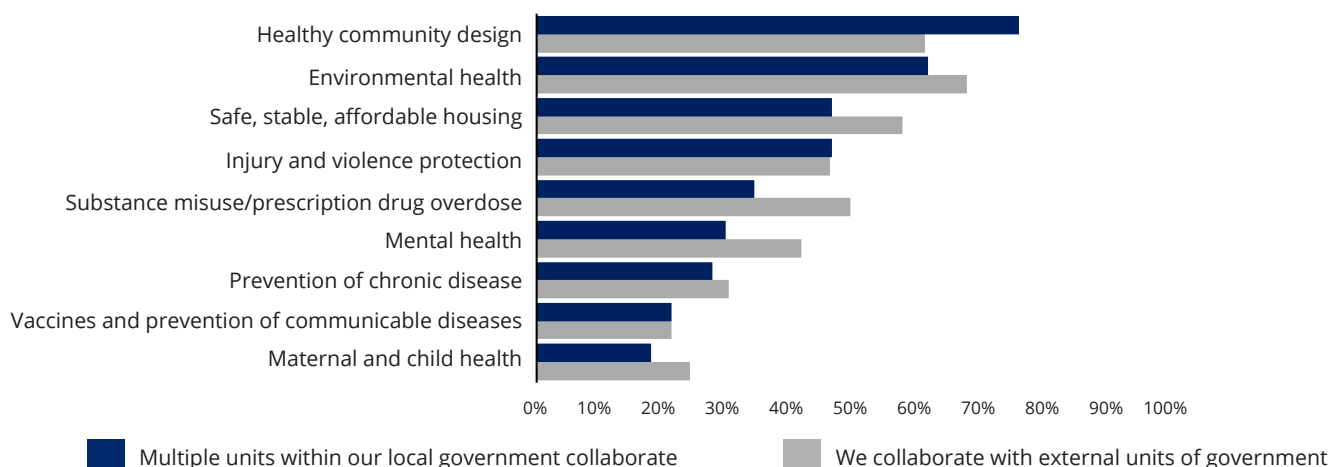
Figure 2: *Would you say your local government is actively working on any of the following issues? (n = 287)*

Issue	Percent
Healthy community design	85%
Environmental health	77%
Safe, stable, affordable housing	61%
Injury and violence protection	57%
Substance misuse/prescription drug overdose	49%
Mental health	43%
Prevention of chronic disease	38%
Vaccines and prevention of communicable diseases	29%
Maternal and child health	26%
These are outside the purview of our local government	5%

and violence prevention (57 percent). While some of these priorities are likely to have shifted since the onset of the COVID-19 pandemic (e.g., vaccines and the prevention of communicable diseases), many of these (e.g., healthy community design, environmental health) are long-standing areas of focus for local governments that they are likely to still be actively working on.

Next, respondents were asked about whether they collaborate with internal and/or external partners on each of these issues. Across various issues, most collaborations were about as likely to involve multiple internal partners (e.g., various departments within the agency) as external units of government (e.g., other units of city, county, or special district government, regional agencies, or other stakeholders) (Figure 3).

Some notable exceptions included healthy community design; safe, stable, affordable housing; substance misuse/prescription drug overdose; and mental health. For healthy community design, local government staff were more likely to be working with partners within their city, county, or special district government unit. For the other three topic areas, they were more likely to be working with other units of city, county, or special district government; regional agencies; or other stakeholders.

Figure 3: *External and Internal Collaboration (n = 263)*

Issue	Multiple units within our local government collaborate	We collaborate with external units of government
Healthy community design		
Environmental health		
Safe, stable, affordable housing		
Injury and violence protection		
Substance misuse/prescription drug overdose		
Mental health		
Prevention of chronic disease		
Vaccines and prevention of communicable diseases		
Maternal and child health		

The survey then asked more detailed questions on three specific areas of collaboration: (1) healthy community design; (2) safe, stable, affordable housing; and (3) substance misuse/prescription drug overdose. These three topic areas were selected based on their timeliness, existing knowledge gaps, and the breadth of topics and partners potentially involved in the collaborations.

Healthy Community Design

The first specific topic area, healthy community design, includes initiatives and issues such as walkability/mobility, parks, and complete streets.

Healthy community design was the most common area of internal collaboration (71 percent) and second most common for external collaborations (57 percent; see Figure 3). For healthy community design,

governments were generally more likely to be working with internal partners (e.g., various departments within the agency), rather than with external units of government (e.g., other units of city, county, or special district government; regional agencies; or other stakeholders).

As shown in Figure 4, the internal governmental partners that were most likely to be collaborating to address this issue were planning and development (92 percent), public works (89 percent), administration (85 percent), and parks and recreation (84 percent).

When they collaborated with external units of government, it was most often with transportation (54 percent), public health (46 percent), environmental/natural resources (45 percent), or education (43 percent).

Figure 4: *Governmental partners involved in addressing healthy community design (n = 225)*

Within the local government   External unit of government
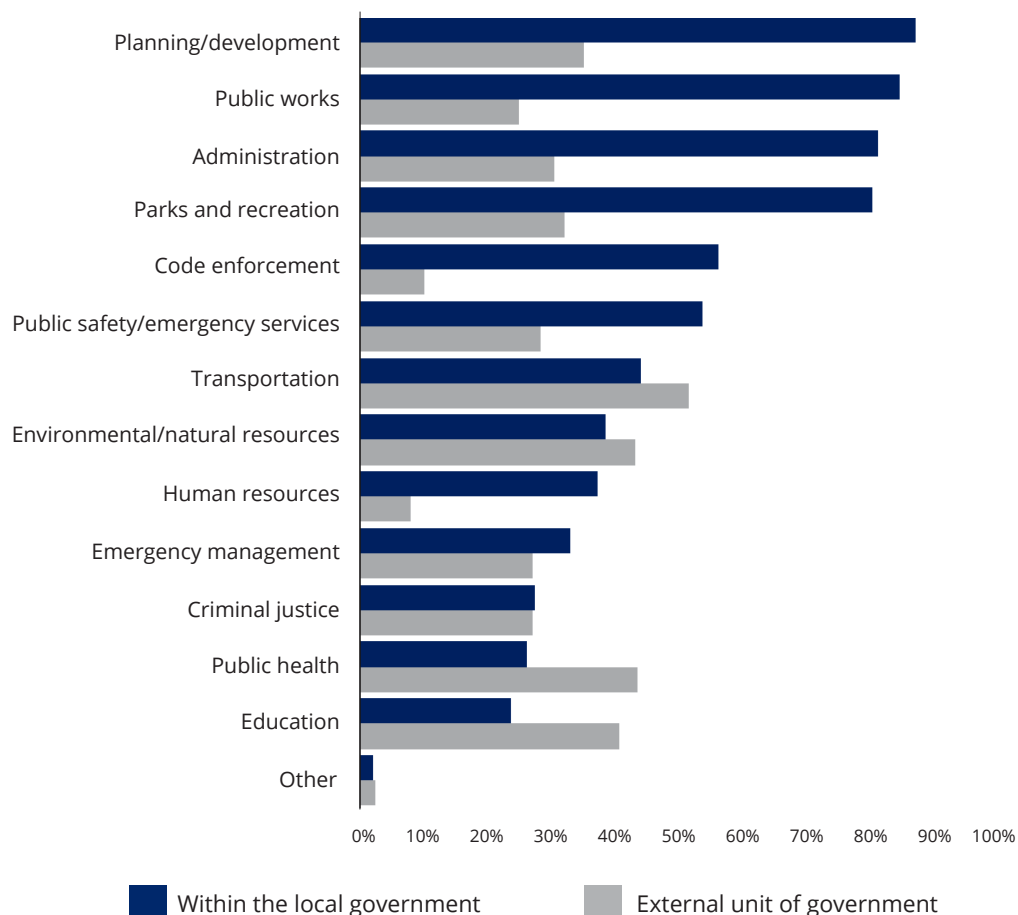
More than half of the jurisdictions responding indicated that their healthy community design collaborations have been in place for more than one year (57 percent). Meanwhile, about 1 in 4 (28 percent) reported that some were well-established, while others were fairly new (Figure 5). This may reflect the long-time focus that local government agencies have had on cross-sector collaborations with multiple local government partners to address healthy community design, and the degree to which this issue is at the intersection of many government agency functions.

Figure 5: *How long have the governmental partners been collaborating to address healthy community design? (n = 225)*

- Less than one year
- More than one year
- Some well-established, others still fairly new
- Don't know/no response
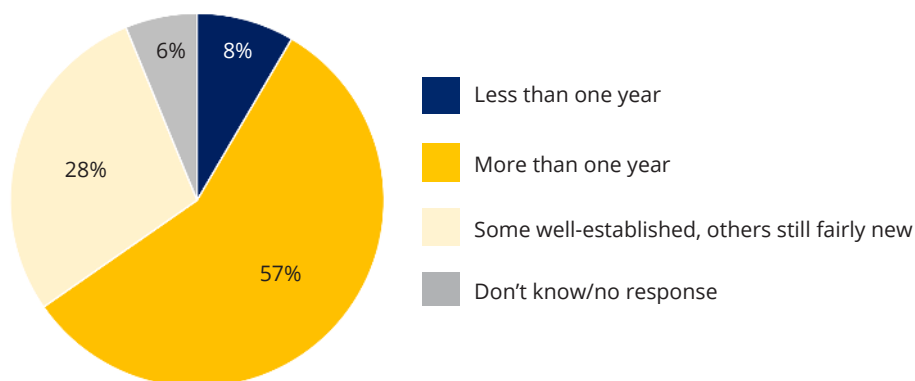
Respondents were also asked about the nature of the collaboration, meaning whether they were informal (including interpersonal contacts and informal channels of communication, like ad hoc meetings, correspondence, and phone calls) or formal (including organizational structures, job definitions, plans, agreements, contracts, and MOUs).

For all three of the specific program areas surveyed, the collaborations included both informal and formal components. Healthy community design exhibited the largest difference between the two, with 69 percent informal vs. 54 percent formal partnerships (Figure 6).

Figure 6: *What is the nature of the healthy community design collaboration? (n = 225)*
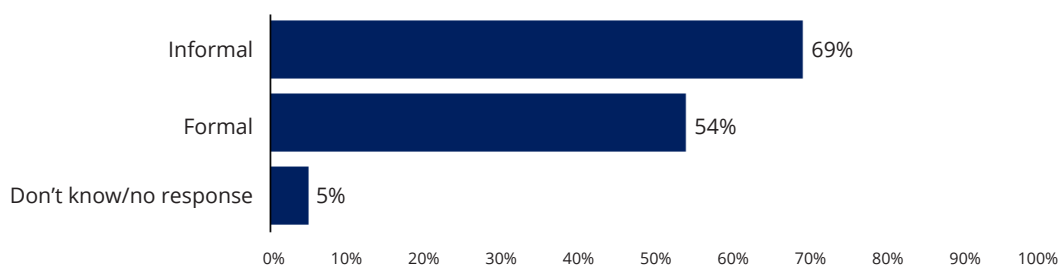
As shown in Figure 7, the primary champions of healthy community design collaboration have been local government administration (i.e., the administrator in a council-manager community) (86 percent) and department heads (i.e., those who report to the administrator) (83 percent), reflecting the key role that leadership support plays in establishing and maintaining cross-sector collaborations.

Figure 7: *Who have been the main champions of the healthy community design collaboration? (n = 215)*
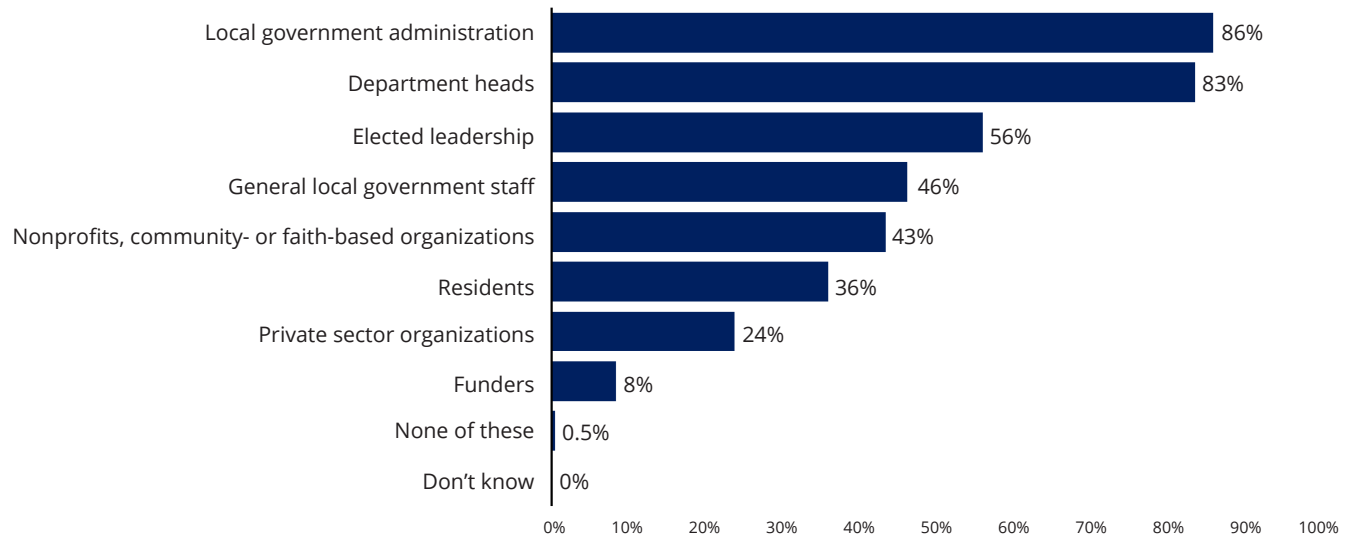
Respondents were asked about current or future plans for evaluation of the success of the collaboration. About 1 in 4 respondents (27 percent) indicated that they have evaluated the success of their healthy community design collaboration.

Of the three programmatic areas surveyed, healthy community design exhibited the highest percentage of respondents (31 percent) saying that they were not planning to evaluate the success of their collaborations (Figure 8). This may relate to issues in identifying outcome metrics for what may be long-term efforts with indirect impacts, and to the more informal nature of the collaborations (i.e., evaluation plans are less likely to be built into informal agreements).
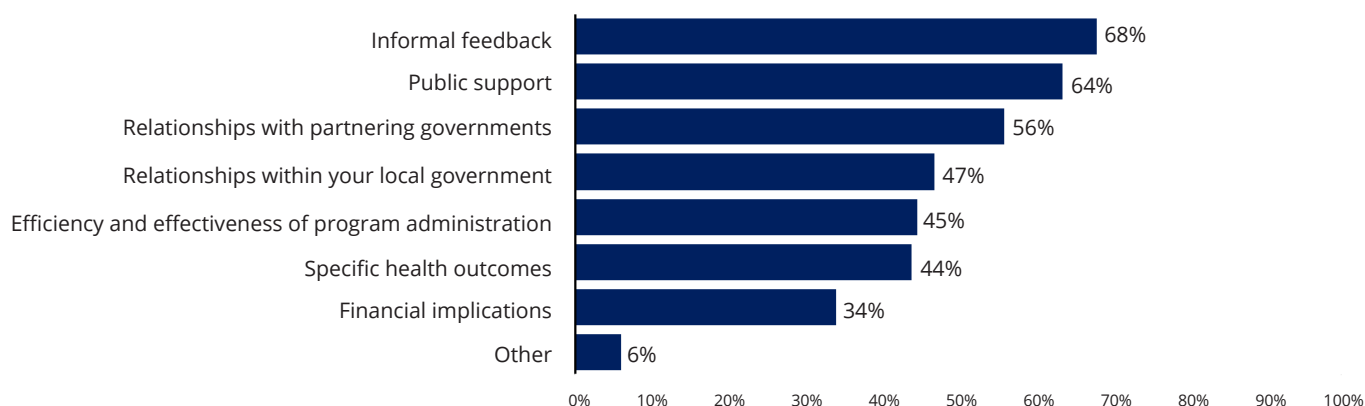
Figure 8: *Have you evaluated the success of any aspects of the healthy community design collaboration? (n = 225)*
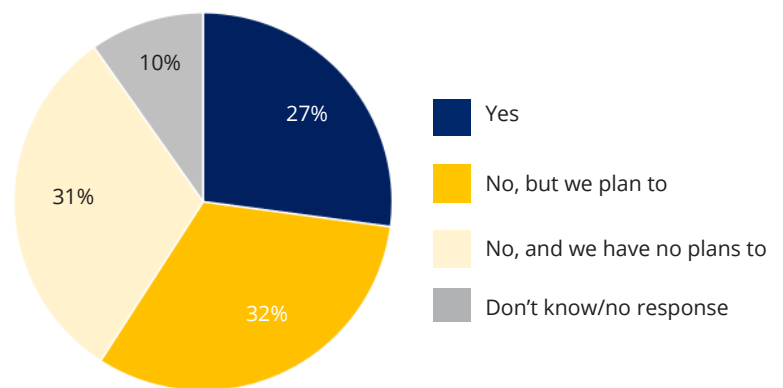
When the success of the healthy community design partnership is evaluated, it is most often done through informal feedback (68 percent), public support/satisfaction surveys (64 percent), or through relationships with partnering governments (56 percent; see Figure 9). Again, this may be a function of the more informal nature of these partnerships, as well as challenges in developing metrics for success in specific health outcomes that can be clearly tied to improvements in healthy community design.
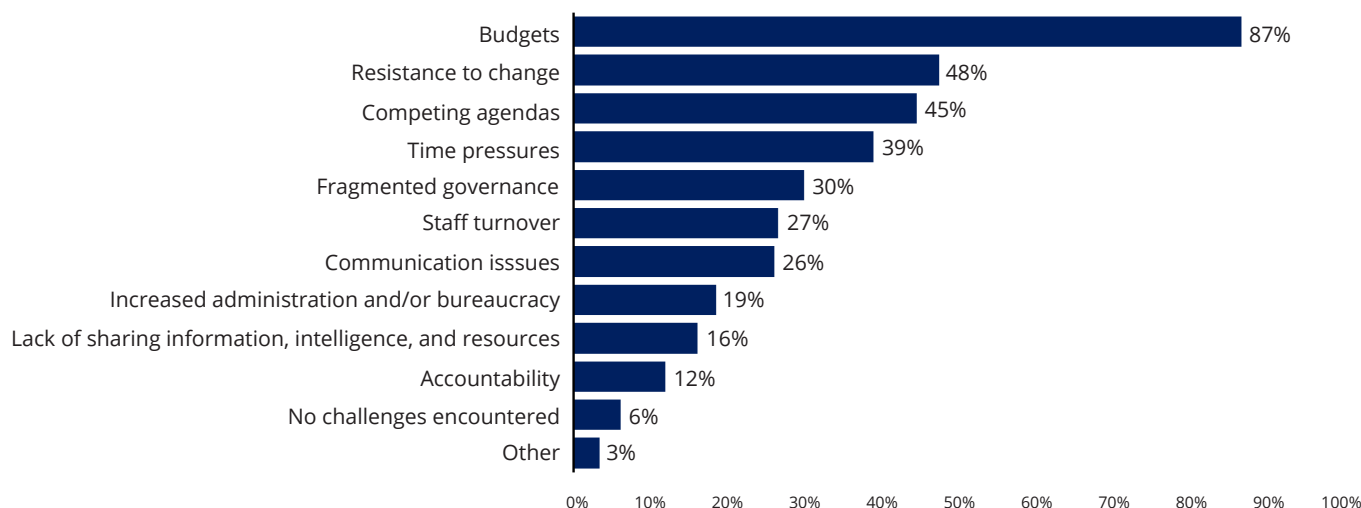
Figure 9: *How have you evaluated/how do you plan to evaluate the success of the healthy community design collaboration? (n = 132)*

Category	Percent
Informal feedback	68%
Public support	64%
Relationships with partnering governments	56%
Relationships within your local government	47%
Efficiency and effectiveness of program administration	45%
Specific health outcomes	44%
Financial implications	34%
Other	6%

When asked about the challenges that jurisdictions are facing when collaborating on healthy community design, respondents indicated that the primary challenges encountered were budgets (87 percent), followed to a lesser extent by resistance to change (48 percent), and competing agendas (45 percent; see Figure 10). Given the need for local governments to maintain a balanced budget despite limited resources, it is not surprising that budget was cited as a top challenge.

Figure 10: *Has your local government been challenged by any of the following when collaborating on healthy community design? (n = 210)*

| Category	Percent
Budgets	87%
Resistance to change	48%
Competing agendas	45%
Time pressures	39%
Fragmented governance	30%
Staff turnover	27%
Communication isssues	26%
Increased administration and/or bureaucracy	19%
Lack of sharing information, intelligence, and resources	16%
Accountability	12%
No challenges encountered	6%
Other	3%

In the open-ended comments that respondents added regarding their healthy community design collaborations, they noted partnerships with local hospitals, universities, and councils of government, as well as community hiking groups and locally run fitness challenges. Initiatives cited included complete streets policies, focus on childhood obesity and access to healthy foods, and incorporation of equity metrics.

Safe, Stable, Affordable Housing

The second specific program area asked about was safe, stable, affordable housing, which includes issues such as housing accessibility and homelessness.

While safe, stable, affordable housing was the third-most common area for either internal or external collaborations, the range of departments or agencies involved in these collaborations was narrower than for healthy community design. Collaborations focused primarily on internal partnerships with planning/development, administration, code enforcement, and public safety, and external partnerships with other agencies' planning/development, administration, and public health operations[3] (Figure 11).
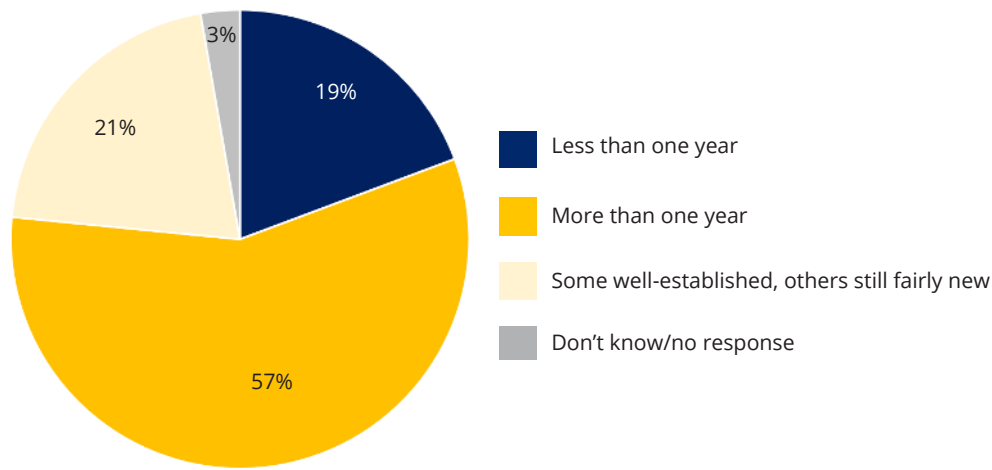
Figure 11: *Governmental partners involved in addressing safe, stable, affordable housing (n = 145)*
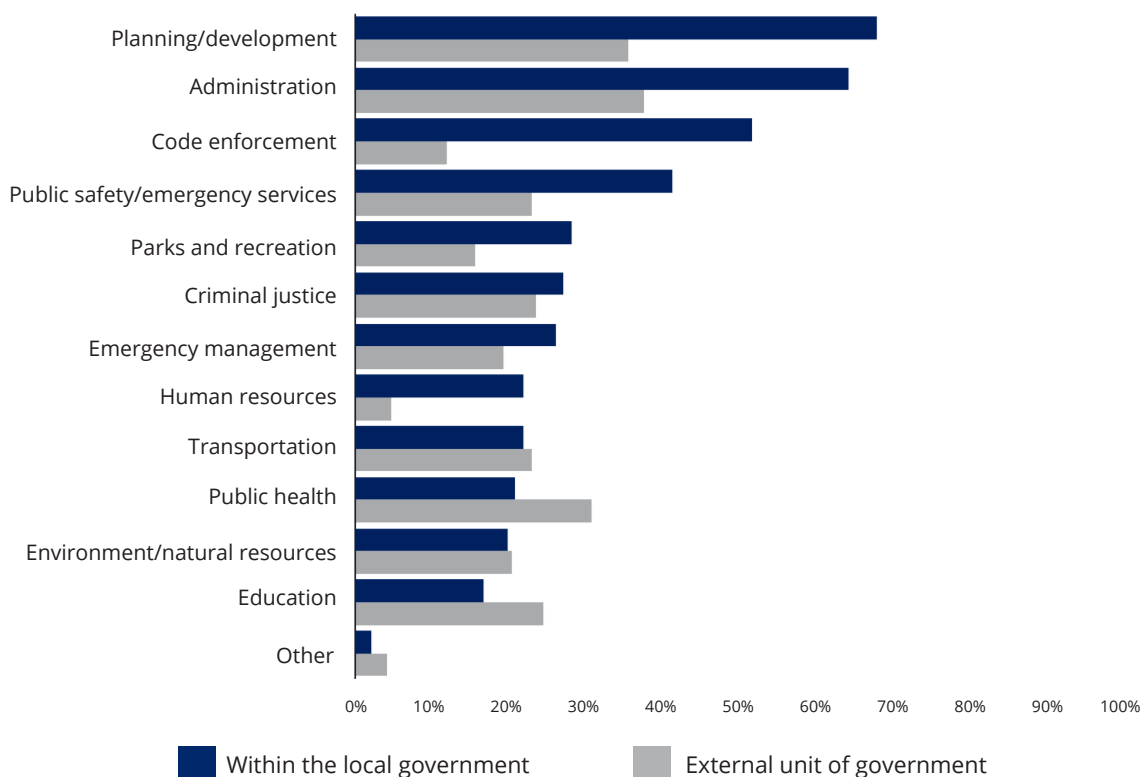
More than half (57 percent) of partnerships for safe, stable, affordable housing have been in place for more than one year (Figure 12), again likely reflecting the long-standing focus of multiple government agencies on safe, stable, affordable housing.

Compared with healthy community design, the area of safe, stable, affordable housing is more than twice as likely to involve partnerships that have been in place for less than a year (8 percent vs. 19 percent; see Figures 5 and 12).

Figure 12: *How long have the governmental partners been collaborating to address safe, stable, affordable housing? (n = 145)*

- Less than one year
- More than one year
- Some well-established, others still fairly new
- Don't know/no response

In the case of safe, stable, affordable housing, the same percentage of jurisdictions (65 percent) reported engaging in formal and informal collaborations (Figure 13).

Figure 13: *What is the nature of the safe, stable, affordable housing collaboration? (n = 145)*
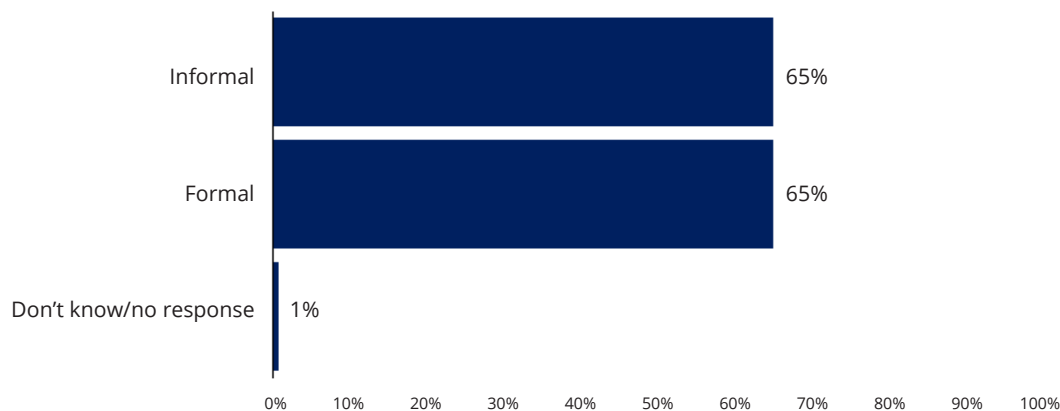
Similar to the results for healthy community design, local government administrators, department heads, and elected leadership have been the main champions of safe, stable, affordable housing efforts (Figure 14).

Champions also include nonprofit, community-based, or faith-based organizations, who often interact with those in need of safe, stable, affordable housing.

Figure 14: *Who have been the main champions of the safe, stable, affordable housing collaboration? (n = 144)*
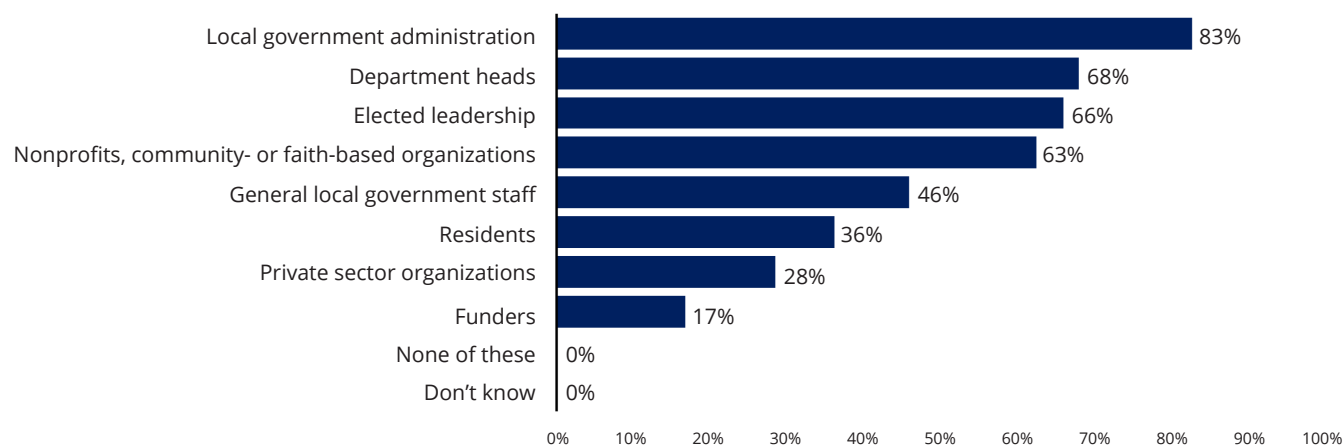
Of the three programmatic areas surveyed, housing collaborations exhibited the highest percentage saying that they were either currently evaluating the success

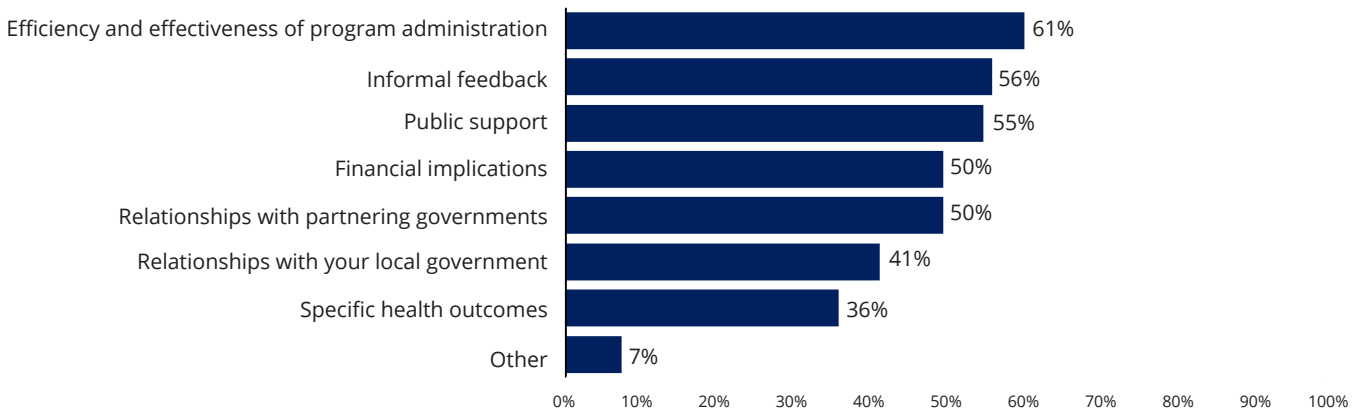of their initiatives or planning to do so (66 percent; see Figure 15).

Figure 15: *Have you evaluated the success of any aspects of the safe, stable, affordable housing collaboration? (n = 145)*
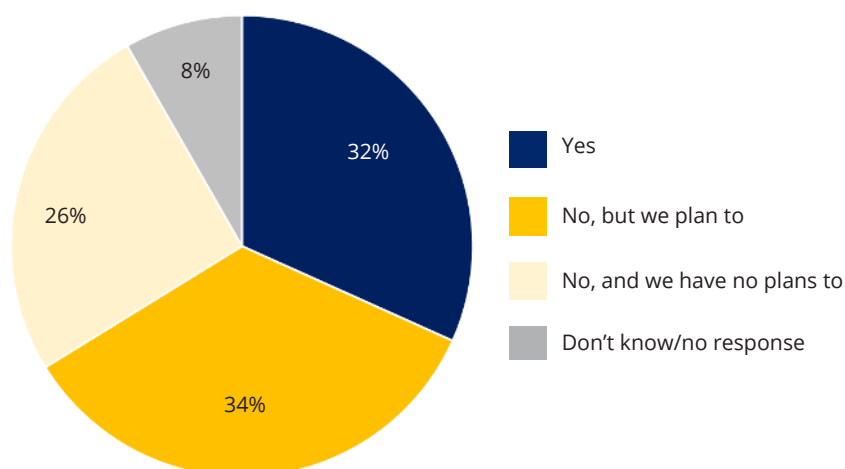
For safe, stable, affordable housing, the primary method of program evaluation was the efficiency or effectiveness of program administration (61 percent), followed by informal feedback (56 percent) and public support (55 percent; see Figure 16).
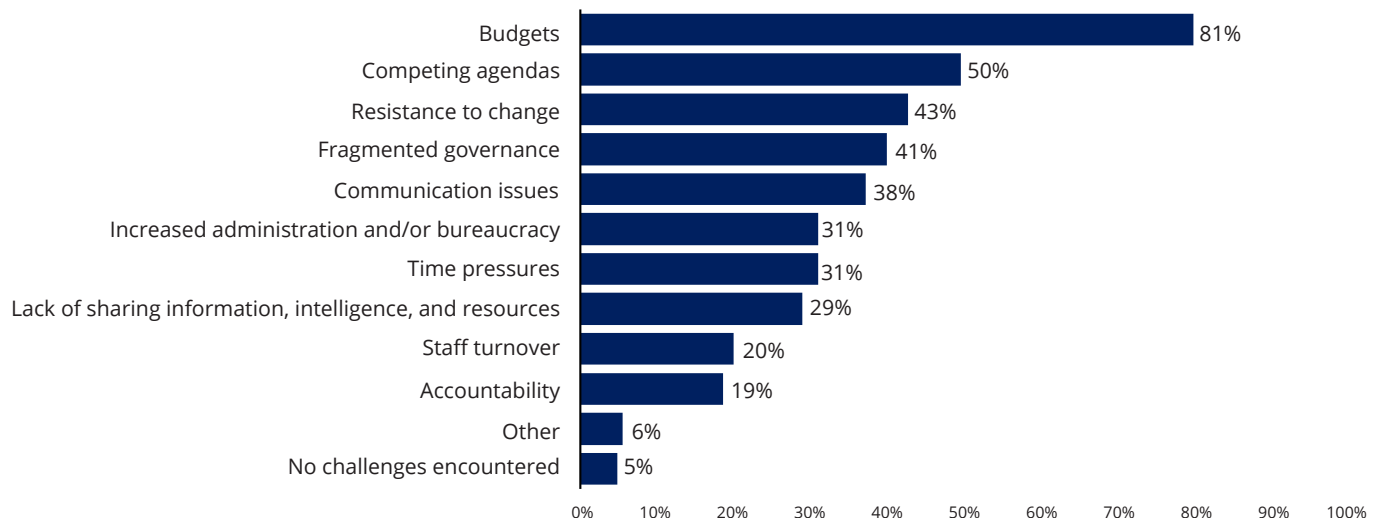
Figure 16: *How have you evaluated/how do you plan to evaluate the success of the safe, secure, affordable housing collaboration? (n = 94)*

Efficiency and effectiveness of program administration	61%
Informal feedback	56%
Public support	55%
Financial implications	50%
Relationships with partnering governments	50%
Relationships with your local government	41%
Specific health outcomes	36%
Other	7%

As with healthy community design, the primary challenges encountered have been budgets (81 percent), competing agendas (50 percent), and resistance to change (43 percent; Figure 17).

Figure 17: *Has your local government been challenged by any of the following when collaborating on safe, stable, affordable housing? (n = 143)*

|	
Budgets	81%
Competing agendas	50%
Resistance to change	43%
Fragmented governance	41%
Communication issues	38%
Increased administration and/or bureaucracy	31%
Time pressures	31%
Lack of sharing information, intelligence, and resources	29%
Staff turnover	20%
Accountability	19%
Other	6%
No challenges encountered	5%

In the open-ended comments, several respondents cited community resistance to affordable housing, such as concerns about higher densities, changes in neighborhood character, or attitudes toward people experiencing homelessness. Others noted a scarcity of willing developers or available funding, and related impacts on the government and other local employers in being able to find affordable housing stock for their employees.

Substance Misuse/Prescription Drug Overdose

The third area of in-depth survey questions was substance misuse/prescription drug overdose (e.g., opioids, cannabis, alcohol, or tobacco).

Here, the most common partners are in public safety, criminal justice, public health, and education (see Figure 18)—reflecting a varied focus on prevention, treatment, and enforcement to address substance misuse.

Figure 18: *Governmental partners involved in addressing substance misuse (n = 109)*
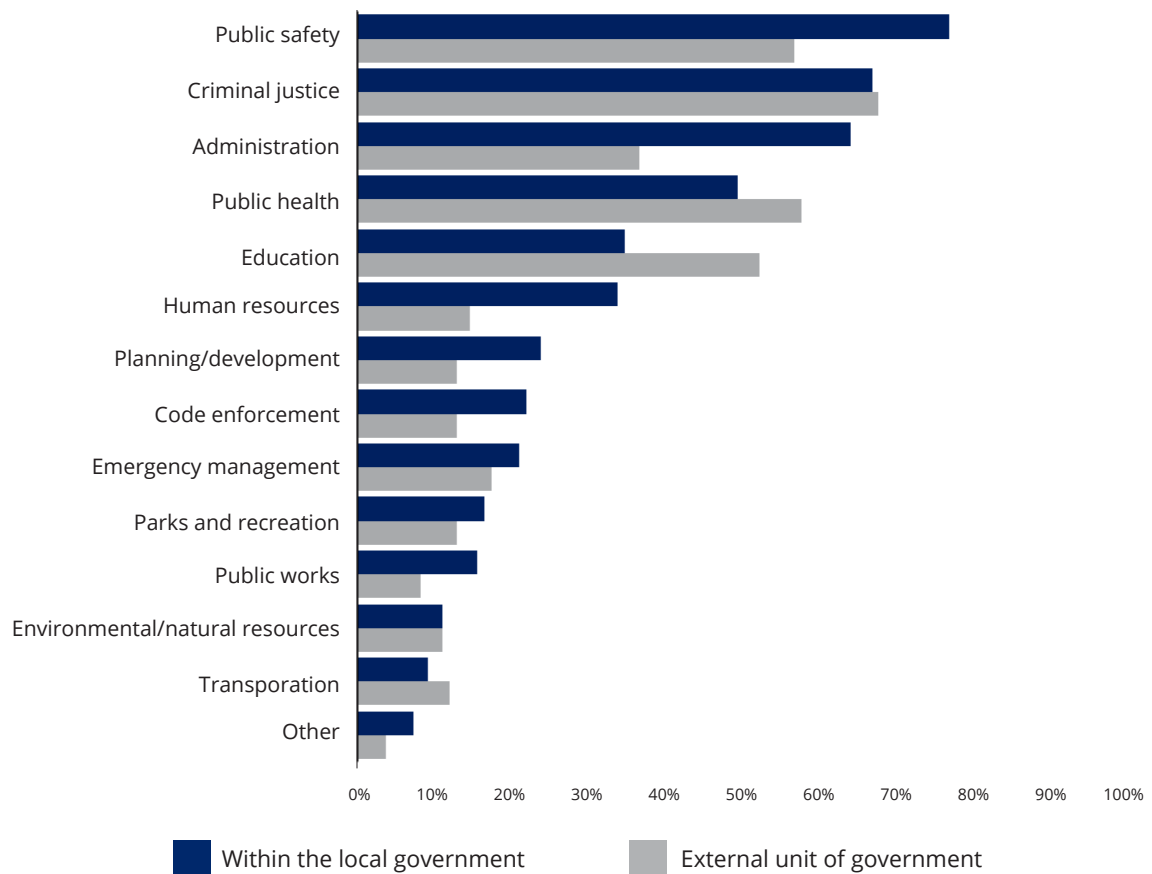
Similar to safe, stable, affordable housing, more than half (53 percent) of partnerships for substance misuse have been in place for more than one year. About 1 in 4 collaborations (24 percent) consist of some well-established and some fairly new partnerships (Figure 19).

Unlike healthy community design, the area of substance misuse is more than twice as likely to involve partnerships that have been in place for less than a year (8 vs. 18 percent; see Figures 5 and 19). This may reflect substance misuse being a newer area of focus for cross-sector collaborations.
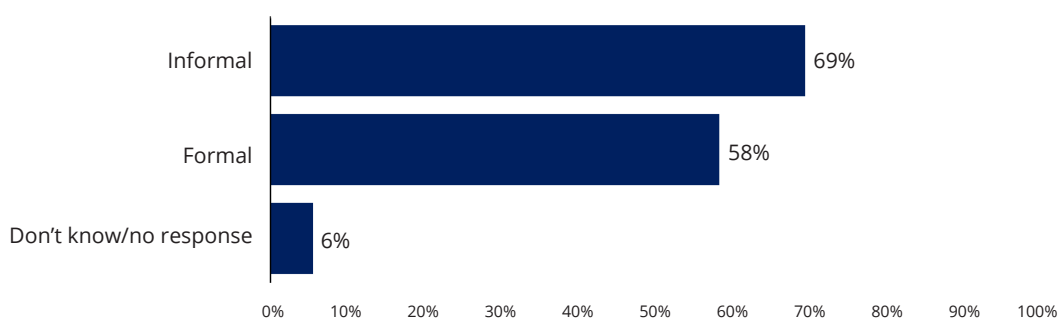
Figure 19: *How long have the governmental partners been collaborating to address substance misuse? (n = 109)*
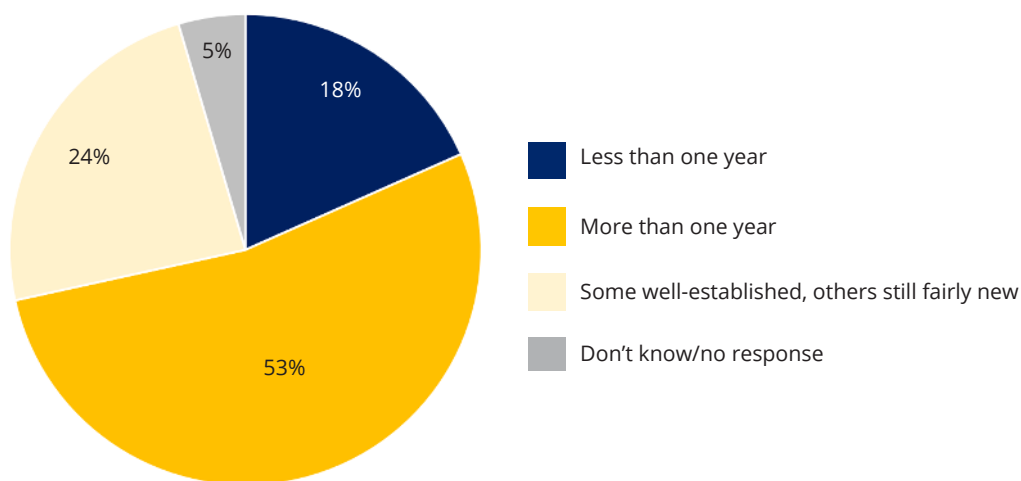
Collaborations on substance misuse are somewhat more likely to be informal than formal in nature (69 percent vs. 58 percent; see Figure 20).
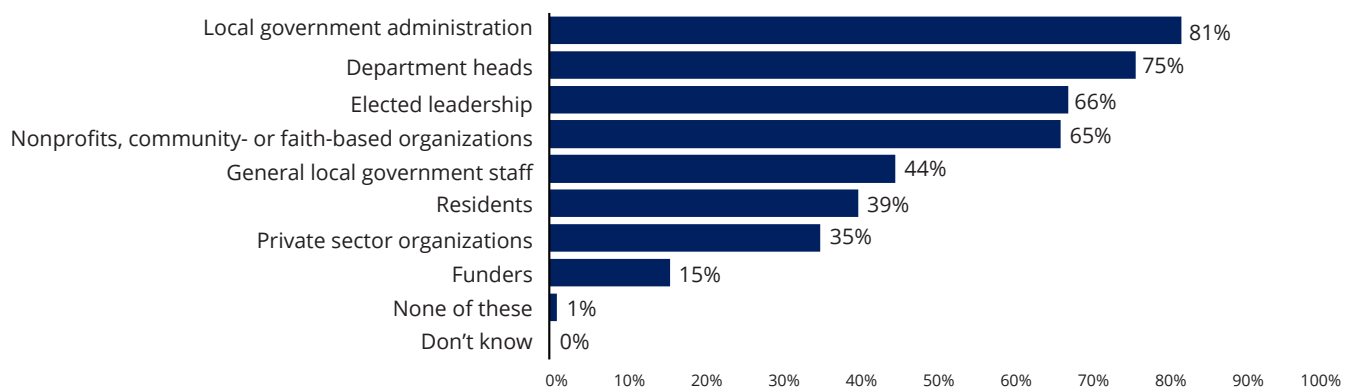
Figure 20: *What is the nature of the collaboration around substance misuse? (n = 109)*

Like safe, stable, affordable housing, the main champions of collaborations around substance misuse were local government administrators, department heads, elected leadership, and nonprofits, and community- or faith-based organizations (Figure 21). Of the three programmatic areas surveyed, substance misuse was the one with the highest percentage reporting that local residents were also serving as champions (39 percent). This may speak to the widespread impact that substance misuse has had on individuals and families within a community, and local residents identifying a need for multiple government agencies to work together to address it.

Figure 21: *Who have been the main champions of the substance misuse collaboration? (n = 104)*

Local government administration — 81%
Department heads — 75%
Elected leadership — 66%
Nonprofits, community- or faith-based organizations — 65%
General local government staff — 44%
Residents — 39%
Private sector organizations — 35%
Funders — 15%
None of these — 1%
Don't know — 0%

More than 1 in 4 respondents (28 percent) reported that they have already evaluated the success of the partnership, and an additional 35 percent plan to do so (Figure 22).

Figure 22: *Have you evaluated the success of any aspects of the substance misuse collaboration? (n = 109)*

- 28% — Yes
- 35% — No, but we plan to
- 22% — No, and we have no plans to
- 16% — Don't know/ no response
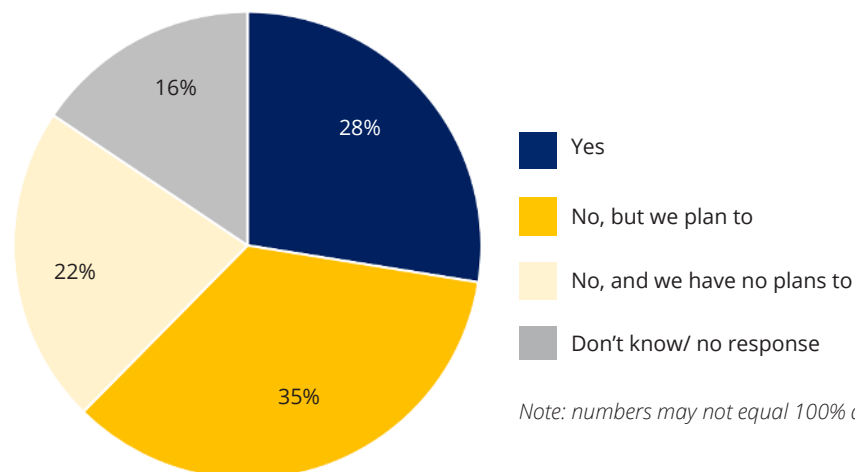
Note: numbers may not equal 100% due to rounding.

For substance misuse, program evaluation is being accomplished via both the tracking of specific health outcomes (74 percent) and the efficiency or effectiveness of program administration (70 percent; see Figure 23). For substance misuse (in contrast to healthy community design and safe, stable, affordable housing), agencies may be more easily able to identify the effect of programs on specific health outcomes.

Figure 23: *How have you evaluated/how do you plan to evaluate the success of the substance misuse collaboration? (n = 66)*
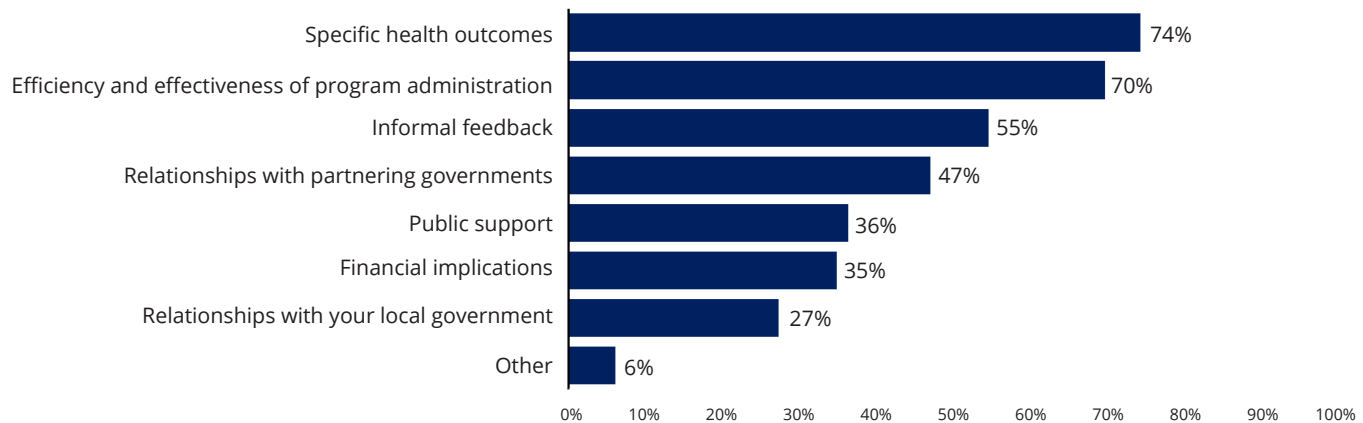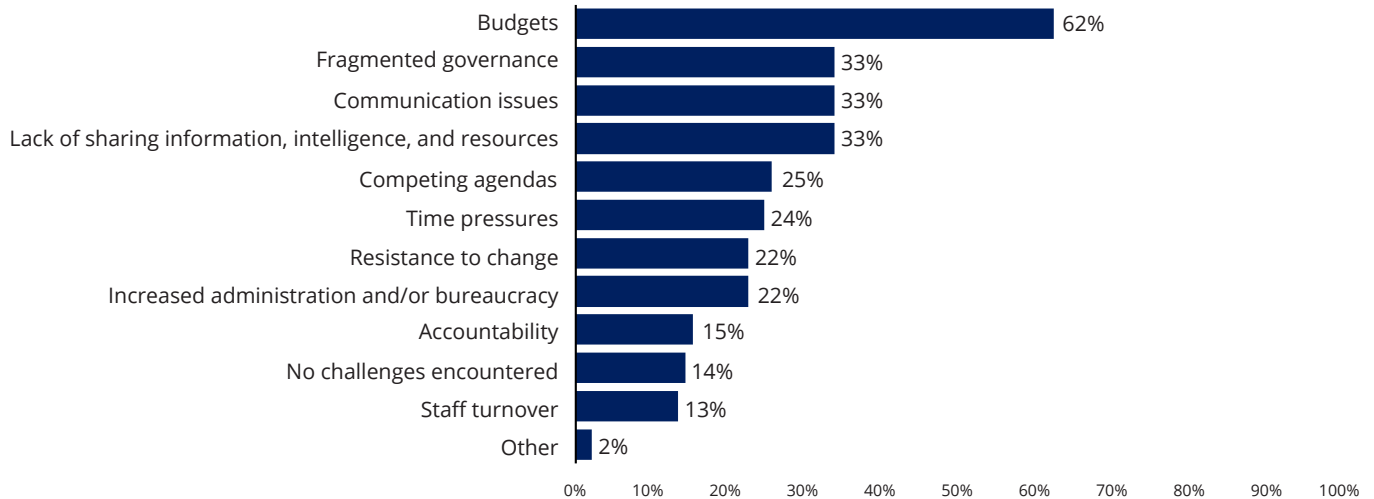

Of the three specific programmatic areas surveyed, efforts to address substance misuse reflected the lowest percentage reporting budgetary challenges (62 percent vs. 87 percent for healthy community design and 81 percent for affordable housing; see Figures 24, 10, and 17, respectively). This is not necessarily an indication that the budgets for one area are higher than another, but perhaps that there has been fluctuation or instability in the amount budgeted. Alternatively, this may reflect the influx of funds that some localities have received in recent years to address substance misuse.

Fragmented governments, communication issues, and lack of sharing information, intelligence, and resources were also cited by 1 in 3 respondents as challenges they have faced when collaborating on substance misuse.

Interestingly, the percentage reporting staff turnover as a challenge was lowest for substance misuse collaborations (13 percent), despite high rates of burnout and turnover among substance abuse counsellors.[4] This may reflect the variety of partners in such collaborations, with potentially lower turnover among those other positions or agencies involved.

Figure 24: *Has your local government been challenged by any of the following when collaborating on substance misuse? (n = 99)*

Challenge	Percentage
Budgets	62%
Fragmented governance	33%
Communication issues	33%
Lack of sharing information, intelligence, and resources	33%
Competing agendas	25%
Time pressures	24%
Resistance to change	22%
Increased administration and/or bureaucracy	22%
Accountability	15%
No challenges encountered	14%
Staff turnover	13%
Other	2%

Comments about collaborations to address substance misuse noted efforts to prioritize mental health, harm reduction, and needle exchanges; programs involving everyone from youth to the elderly; and ordinances regulating pain clinics, pawn shops, and scrap metal sales. Among the special challenges cited was a concern that positive outcomes and return on investment are not always visible within a single budget year or term of elective office.

Summary

From the results of the survey, it is clear that local governments are actively working to address many of today's key public health challenges. To address these issues, they are collaborating with multiple partners within their city, county, or special district government unit, and with external partners (e.g., other units of city, county, or special district government, regional agencies, or other stakeholders). When exploring three programmatic areas in more depth, the frequency of public health agencies as a cross-sector partner varied, with public health agencies more likely to be involved in partnerships addressing substance misuse/prescription drug overdose than in partnerships addressing healthy community design or safe, stable, affordable housing.

The survey results also showed both similarities and differences between the three programmatic areas surveyed in the nature of collaborations (informal vs. formal), the main champions of collaborations, how long collaborations have been in place, if/how they are evaluated, and the challenges faced.

Section 2: Case Studies

While quantitative data such as survey results are ideal for gaining a broad understanding in aggregate of the landscape of cross-sector collaborations, a qualitative approach that can capture more detailed information about specific cross-sector collaborations can help to better understand the nuances of how collaborations are implemented, the outcomes of cross-sector collaborations, and lessons learned. This information, in turn, can help elected and appointed officials adopt or adapt existing models of cross-sector collaboration to meet the needs of their specific jurisdiction.

To obtain more detailed information, three case studies of successful collaborations were conducted based on the results of the survey. Jurisdictions selected for the case studies were from the 287 survey respondents, and met all of the following criteria: (1) jurisdiction actively working on the specific issue, (2) willing to be contacted with follow-up questions, (3) public health (internally or externally) is a governmental partner, (4) collaboration results are being evaluated, (5) collaboration has been established for at least a year, and (6) respondent provided comments on collaboration. Results were further refined to ensure diversity in geographic location, population size, and demographic makeup of population.

Using key informant interviews and document reviews, the case studies of the city of Arvada, Colorado (healthy community design), the county of Sarasota, Florida (safe, stable, affordable housing), and the county of Hennepin, Minnesota (substance misuse/prescription drug overdose) describe their collaborations and offer recommendations for best practices.

Case Study - Healthy Community Design: City of Arvada, Colorado

Jurisdiction and State:
City of Arvada, Colorado

Square Miles:
35 square miles (land only, 2010)

Population:
120,492 (2018)

Population Density:
3,429 people/square mile (2018 est.)

Urban/Rural Classification:
Urban

Poverty Rate:
5.9%

Median Income, 2014-2018:
$80,055

Local Health Department Annual Expenditures:
$17.9 million (Jefferson County, 2018)

A first-ring suburb of Denver, Arvada has grown substantially over the last several decades into the eighth-largest city in the state.[5]

Scope of Activities and Implementation

Arvada's recent efforts to design a healthier community have centered on linkages, collaboration, and engagement. A program called the Healthy Places Initiative, which ran from 2013 to 2016, provided a framework for connecting multiple threads of activities promoting active living in Arvada: investments in bike, pedestrian, and recreation infrastructure; comprehensive and targeted planning efforts; and community engagement processes and programming. All of this work involved significant collaboration across the local government, with other public and private partners, and with community residents—including those previously left out of the conversation. In addition to the direct impacts on community infrastructure, the approach modeled a fundamental shift in how government collaborates for and with its residents.

While initially supported by a central initiative coordinator, enterprise-wide reorganization reinforced the collaborative approach modeled in these efforts so that staff across the organization—from the city manager's office to the departments of parks, public works, and community and economic development—remain engaged without a dedicated facilitator. Integration of strategies into various long-range planning documents and continued staff commitment to resident engagement also help to sustain efforts beyond the initial program.

Motivations and Catalysts

Colorado has long ranked among the healthiest states in the United States on a range of indicators, but high performance on aggregate measures does not necessarily translate to equitable outcomes for all community residents. As awareness of the social determinants of health spread across the globe in the last two decades, public and private public health stakeholders in Colorado became increasingly focused on creating enabling environments for active living. In an effort to ensure all pockets of the community had similar opportunities to live active, healthy lifestyles, staff successfully applied for funding from the Colorado Health Foundation's Healthy Places Initiative (HPI) in late 2012. Healthy Places targeted an approximately five-square-mile area in southeast Arvada that contained both historic and newly developed commercial districts,

as well as three new transit stations. Residents of its middle-to-lower-income residential areas were more vulnerable to health inequities.

Arvada kicked off the three-year initiative with survey work and additional fact-finding efforts to engage the community around creating healthy spaces. While engagement was always critical to the design of new facilities in Arvada, this process was unique given its focus on the "as-built" environment: Why were certain parks and recreational amenities underused? What types of barriers impeded resident connectivity and active lifestyles in the target area?

An interdisciplinary team was formed, co-led by the parks department and the city manager's office. It included additional representation from public works, multiple boards and commissions, neighborhood groups, local schools, and support from numerous other community partners, including Jefferson County Public Health. As Director of Vibrant Community and Neighborhoods (and head of the parks department) Gordon Reusink emphasized, "A lot of concerted effort was made to ensure we really understood our community; who lives here, were there voices that we should be hearing from that we hadn't been hearing from? Even once they were identified, how do we hear from them?" This initially prompted the hiring of translators, and later, the hiring of community members to function as "Community Connector" liaisons. "An awful lot of the first work was just making sure that we had a really credible plan, where we knew we were hearing from everyone in the community," Mr. Reusink said.

Collaboration has long been a hallmark of community development in Arvada, but a restructuring of local government operations institutionalized the practice. As the HPI work unfolded, Arvada's city manager and council were leading a new strategic planning process that organized the government's functions around their impact on residents' quality of life. It established different dimensions of the community as core priorities, including vibrant neighborhoods, infrastructure, and safety. Internally, departments and work systems were also realigned to reduce silos and reinforce these cross-cutting priorities, and an online dashboard provides public access to its strategic principles, objectives, and performance measures.

Partners and Champions

Key champions in these formally aligned efforts to promote a vibrant community and neighborhoods include the city manager's office (home to the HPI coordinator and the neighborhood engagement coordinator), the parks department, and transportation divisions of the public works department. As the following examples illustrate, each brings their own expertise and leads efforts in their respective domains, but regularly works together and with additional partners.

Community Mobility and Active Transportation. Transportation planning staff had engaged in some cross-training with public health colleagues over time, but a decade back, concepts such as complete streets or vision zero were still fairly new to suburban areas like Arvada. Staff looked to other places such as Seattle for inspiration on how to incorporate health elements into the early stages of planning and decision making on transportation issues.

Within the HPI frame, staff focused on trying to remove barriers to community mobility. Through a combination of design and infrastructure changes, their goal was to make it as easy as possible for people to connect from their neighborhood to the destinations around them. "We've tried to package the intent of health and active transportation into each and every one of those projects, as they've moved forward from high-level discussions with our community members about what they're looking for, what their troubles are, what they're experiencing, to technical aspects of, 'Can we reduce crosswalk distance and make it easier for the aging population to utilize the infrastructure?'" said Senior Transportation Planner John Firouzi. Through collaboration with and training from local, regional, and national experts, "now we have more documents and standards that we can fall back on as a proven process in other parts of the country where safety has a huge effect on public health."

Parks and Recreation. Through the HPI, parks staff set out to reverse underutilization of neighborhood facilities. The Arvada Park Advisory Committee was a key resource in developing the strategy with significant public input. Eventually focusing on two parks based on usage data and park age, as well as socioeconomic indicators of the surrounding neighborhoods, the city

invested in new fitness equipment, seating and other aesthetic improvements, and a secure dog park area. All were based on what the neighborhood residents identified as priorities.

Partners were not only key in bringing voices to the initial conversations, but in reinforcing the active living goals as improvements rolled out. For example, one member of the advisory commission was a physician, and helped launch a park prescription plan in which doctors recommend twice-weekly 20-minute walks to their patients (the wayfinding signs in and around the parks point out specific routes). The local YMCA began holding free fitness programming in the parks, and schools and other sports and recreation organizations have also made use of the facilities. "It's an easy sell," Mr. Reusink said of establishing partnerships leveraging the parks system, noting that priorities typically complement, rather than compete.

While certainly benefitting from a rich network of partners, the city ultimately controls decision making around healthy community design. Jefferson County Public Health is one of many stakeholders with overlapping interests in active living, and its staff are engaged on specific projects and programs as appropriate, such as development of 2016 Parks, Trails, and Open Space Master Plan. Likewise, Arvada's Healthy Places staff liaise with relevant initiatives coordinated by the health department, such as Jefferson County Health Improvement Network's Active Living Coalition.

Resources

The Healthy Places Initiative grant from the Colorado Health Foundation provided a $1-million investment in these activities. Over the three-year period, funds were primarily used to pay for staff, including the initiative coordinator and the Community Connectors, and the park improvements. Not all tactics carried a hefty price tag; for example, wayfinding signs typically cost between $12 and $15 each.

Following the formal program's sunset, Arvada maintained a neighborhood engagement coordinator position (salary range $53,000-$72,000) to support a broad spectrum of issues, beyond just healthy communities. The city also continues to employ residents as "Community Connector" liaisons on an as-needed basis (recently, for example, around the census), paid at an hourly rate of $15.

While not an insignificant infusion of funds overall, the process was designed to be sustainable in that it institutionalized collaboration around design for community health. Staff across multiple departments now routinely consider the health impacts of development decisions without requiring dedicated funding to support the process.

Measuring and Evaluating Outcomes

In 2013, a statewide nonprofit called Lifewell Colorado launched its HEAL (Healthy Eating Active Living) Cities and Towns Campaign to track the adoption of local policies. Its assessment of nearly 50 municipalities over several years provided benchmarking criteria. In 2016, Arvada was awarded its highest recognition for policies and activities promoting a healthy community.

On an ongoing basis, Arvada county staff monitor a range of indicators to track the impacts of their work, many of which are embedded in the city's strategic framework and can be accessed through the dashboard.

In addition to daily park usage data, which have increased over time, staff tracks the usage of indoor recreation centers since incentivizing outdoor activities has been a priority. They also apply a rating system to assess the condition of all parks, and noted that the dog park installed through the HPI has been at the top "green level" consistently since Day 1—evidence of the neighborhood taking ownership and the park becoming part of everyday life. In 2016, the city was able to increase its master plan goal around neighborhood park access from within a 10-minute walk to within a five-minute walk.

Staff are also monitoring active transportation data related to different combinations of modes of transportation, looking at how people arrive at public transit stations (parking rates vs. transit boarding rates) and counts of people taking bikes on trains.

Community connectivity is another critical dimension of these efforts. Twice a year, the city conducts a brief survey tracking the degree to which residents feel a sense of community. While overall there appears room to grow here citywide (and this is a difficult thing to measure), staff report clear evidence that community engagement in the HPI target areas has paid off.

In addition to use of and care for the dog park, they have seen formalized neighborhood organizations emerge and flourish. "Having the opportunity to activate that park as a community asset really brought people together," said current Neighborhood Engagement Coordinator Charise Canales. "They really used the healthy places grant as a launching pad."

Finally, the lasting impacts on collaboration across the organization are profound. Even several years out from the HPI grant, "At no time have we worked more closely with our transportation colleagues than we do now," said Mr. Reusink, echoing Mr. Firouzi's sentiment about the public health-transportation nexus. "Everything is much stronger now with so many more ways to collaborate and engage people."

Challenges, Successes, and Lessons Learned

The planning and investments made through Arvada's healthy places work were about making it easier for residents to maintain a more active, connected lifestyle. While direct indicators of those behaviors are important, it's also interesting to note community participants' perception of the process. "They still talk very positively about the experience," said Ms. Canales, who took on her role in 2017. But they don't talk about it as an effort to improve public health, she continued. "They focus on the social side and taking ownership of the neighborhood park as an asset."

Mr. Reusink noted that the interdisciplinary team made an effort early on to adopt some shared language about healthy places, which was then used in reporting and outreach about the project. However, over time, he observed, it may not have been used as consistently—perhaps as the new priorities around community vibrancy came to the fore.

Varied perspectives on the outcomes of this collaboration are hardly cause for concern. Citing continued investment in staffing and approaches piloted through HPI, City Manager Mark Deven also pointed to the lasting impact on community engagement as one of the most significant successes of the work, as well as its example of aligning government activities around cross-cutting impacts on quality of life.

Indeed, the lessons in thoughtful planning and its impacts on collaboration and partnerships can potentially be replicated without a similar infusion of funds. "The city's strategic plan really helped because rather than looking at things through traditional departments, we look at the impact on people's lives. That's the basis for the whole work system. It's made it a lot easier to collaborate and identify who's at the table and who's not at the table," said Mr. Reusink. "Support from leadership was really critical in helping us think about what would most help the community to advance." Embedding responsibilities into a series of additional official planning documents—both comprehensive and targeted—further solidified the foundation for ongoing collaboration.

Managing multiple interests (including from the public) can be messy and takes time, and funding limitations, political struggles, and difficult compromises have factored into this work. Nonetheless, Arvada is convinced collaboration is a necessity, especially on issues impacting community health.

Additional Information

- Strategic Plan
- Dashboard
- Healthy Places Summary

Interviewees (January 13, 2020 and February 25, 2020):

- Mark Deven, City Manager
- Lorie Gillis, Deputy City Manager
- Gordon Reusink, Director of Vibrant Community and Neighborhoods
- John Firouzi, Senior Transportation Planner
- Charise Canales, Neighborhood Engagement Coordinator

Case Study - Safe, Stable, Affordable Housing: Sarasota County, Florida

Jurisdiction and State:
Sarasota County, Florida

Square Miles:
725 square miles (556 land, 169 water)

Population:
433,742 (July 2019)

Population Density:
767 people/square mile (2019 est.)

Urban/Rural Classification:
Urban

Poverty Rate:
10.3%

Median Income, 2014-2018:
$58,644

Local Health Department Annual Expenditures:
$24.5 million (FY20)

Sarasota County is in the southwestern part of the Florida peninsula on the Gulf of Mexico, between Tampa and Fort Myers. The economy is largely service-oriented, driven by tourism and the migration of retirees. While the population is estimated at almost 434,000, during the winter months the local population can increase to over 500,000. Major industries include health care, retail trade, and hospitality.

Scope of Activities and Implementation

Sarasota County's dedication to safe, stable, affordable housing encompasses many governmental and nongovernmental partners involved in a variety of initiatives. As Chuck Henry, health officer, Department of Health in Sarasota and director, Sarasota County Health and Human Services explains, "Health is woven into everything that we do."

From 2016 to 2017, Sarasota County convened an affordability housing advisory committee (AHAC) of residents, government employees, real estate developers, local planners, and not-for-profits, among other stakeholders. The group met regularly, and their meetings led to a variety of recommendations and initiatives focused on affordable housing. These efforts included a focus on tiny homes, accessory dwelling units (ADUs), unified development code, mobility fees, building permits, and using county-owned surplus lands for affordable housing, as well as expedited permitting. They studied where in the community affordable housing existed, the number of units available, and what that meant for the community.

Sarasota County has also developed community health action teams (CHATs), neighborhood-level teams facilitated by local public health staff that target lower-income areas of the county. There are currently four active CHATs.

While Sarasota County's work on affordable housing continues to evolve, their 2020 strategic planning efforts focus on affordable and workforce housing for the service industry and the local government workforce, identifying county-owned properties that are best suited for affordable housing, and inclusionary zoning (a code amendment went to the county commission in August 2020 to finalize this).

Matthew Osterhoudt, director of the Planning and Development Services Department, Sarasota County, leads the charge on many of these initiatives as the county works on a comprehensive strategy for unlocking county surplus properties. In addition to surplus land, there are many defaulted vacant properties in the city of North Port, which the county disposes of and uses the county's portion of the profits toward creating affordable housing. As of early 2020, 182 residential lots are in the process of being sold (all lots have been deemed to have no other government use).

Mr. Osterhoudt and his team have also worked with the county to adopt code amendments to support the use of smaller size units (which can be especially useful for those early in their careers), accessory dwelling units (which allow for more affordable housing units within a single site), and modifying parking requirements to reduce the number of spots required for single and multiple family homes that are less than 750 square feet. Fewer parking spots could result in fewer cars, and so the department is also working to lower mobility fees due to the lower demand on roadways from fewer cars.

Another noteworthy collaboration on safe, stable, affordable housing in Sarasota County is the work of UF/IFAS (Institute for Food and Agricultural Sciences) Extension and Sustainability, a partnership between the University of Florida and Sarasota County. UF/IFAS Extension and Sustainability offers a variety of programs on health and sustainability. Their main focus is on equity and energy efficiency, but they also work on aging in place and designing housing with accessibility in mind.

In 2012, with the help of a Department of Energy (DOE) grant, they began conducting residential energy efficiency education workshops, distributing do-it-yourself kits, and creating educational materials to help Sarasota County residents with energy efficiency. In 2016, they refocused their efforts on lower-income community members, who pay a substantially higher share of their income to electric bills than do median/median-plus income households. Working with the Salvation Army, United Way, Children First, and Habitat for Humanity, they conducted nine workshops reaching 190 low-income households in 2016.

UF/IFAS Extension and Sustainability began an Energy Coach Volunteer Program in 2018. This five-class training series covered topics such as energy and water conservation techniques; low- and no-cost energy upgrades; green building basics; solar energy basics; in-home energy evaluations; financial aid for energy improvements; and building impacts on human health. During these trainings, volunteers learn to do minor energy installations and evaluations for low-income families, provide energy upgrade education, offer one-on-one consultations, and provide do-it-yourself kits to residents.

In 2019, UF/IFAS Extension and Sustainability also started work on the grant-funded Partners for Green Places program. This collaboration between Sarasota County, the City of Sarasota, and the Gulf Coast Community, Sarasota Community and Charles and Margery Barancik Foundations supports nonprofit organizations with energy audits and funding for efficiency improvements. Through this program, 13 environmental and human service nonprofits have received energy, water, and solar audits of facilities; "energy roadmaps" for future investments; and funding for improvement projects. The program also provides client energy education and referrals.

Motivations and Catalysts

Affordable housing in Sarasota County is a significant challenge, with widespread repercussions for individual residents and the entire community. In Sarasota County, 77 percent of all renters and 62 percent of all homeowners with incomes below 80 percent of the area median income (AMI) pay more than 30 percent of their income for housing. Further, 49 percent of renters and 42 percent of homeowners pay more than 50 percent of their income for housing. As of 2015, this translates to a total of 76,613 households in Sarasota County being cost-burdened, and 34,408 being severely cost-burdened.

From 2015 to 2016, the required income to purchase a median-priced home in Sarasota County increased by over 27 percent—the fifth-highest increase of all metro areas in the United States. Only two of the three top growth industries have average annual wages adequate to rent a one-bedroom home at fair market price.

Meanwhile, since 2010, Sarasota County's population has grown by 16 percent, with the region ranking as the tenth-fastest growing in the United States. More workforce housing is needed to meet the growing demand and increase in population. In particular, more multifamily units are needed, with almost 6 out of 10 housing units in Sarasota County currently being detached single family homes, unaffordable to many within the county workforce.

And even when residents are able to find lower-cost homes, inefficient construction and appliances can result in less affordable energy bills, increasing financial hardships. For the many service industry workers in the county who live paycheck-to-paycheck, one major housing problem can force them to move to other areas with more affordable workforce housing.

Partners and Champions

Mr. Osterhoudt cites a number of partners in the various affordable housing initiatives being led by the department of planning and development services. These include municipalities (e.g., some within the City of Sarasota); the office of housing and community development, which includes the City of Sarasota and Sarasota County; City of Venice and City of North Port; Sarasota and Venice local housing authorities; the Department of Health; Habitat for Humanity and similar groups and foundations; and the building industry.

Sara Kane, supervisor of the UF/IFAS Extension and Sustainability program, explains that in addition to UF/IFAS Extension and Sustainability working with many departments within the county, including public health, their main partner in their energy upgrade projects is the Sarasota Housing Authority. Other partners include nonprofits such as Salvation Army, United Way, and Habitat for Humanity.

Resources

Approximately half of the staff for the UF/IFAS Sustainability Office are jointly-funded by UF and Sarasota County, while half are solely Sarasota County-funded. UF/IFAS Extension and Sustainability has been able to conduct its energy upgrade work through a DOE grant. Its Partners for Green Places is made possible by a $350,000 Partners for Places grant.

In their FY 2019 Energy Upgrade annual financial report submitted to the DOE, UF/IFAS Extension and Sustainability reports spending a total of $14,272 on supplies, such as LED lightbulbs, insulation gaskets, foam tape insulation, rope caulk insulation, low-flow shower heads, faucet aerators for the bathroom and kitchen, smart power strips, door sweeps, pipe insulation, toilet leak detection tablets, and toilet water flow bags. An additional $1,901 was spent on other

supplies needed for the energy upgrade sweeps and volunteers, including step ladders, cleaning supplies, shop vacuums, air filters, and other miscellaneous supplies for volunteer workdays.

Measuring and Evaluating Outcomes

In 2017, UF/IFAS' residential energy efficiency education workshops reached 216 households, with $167 in annual estimated energy savings per household. Sixty percent of attendees qualified as low income, addressing the issue of energy inequity. Since 2012, the workshops have reached more than 1,672 households, with $279,000 in annual estimated energy savings from kits.

UF/IFAS Extension and Sustainability are keeping track of how many people they reach, how many devices they distribute, and how many homes they upgrade. They also track testimonials from residents they educate, send out surveys to class participants, and send reports to the Sarasota Housing Authority of what was installed and major and minor repairs that need to be done. According to its annual financial report submitted to the DOE, its FY 2019 energy upgrade accomplishments are as follows:

- Reached 978 people at 21 events with energy and water efficiency information and devices

- Completed 100 energy upgrade sweeps in low-income public housing units

- Completed six energy upgrade educational workshops for 109 attendees

- Completed nine events with one-on-one consultations and device distribution for 745 people

- Maintained work assignments and relationships with energy coach volunteers throughout the year

- Maintained current relationships and developed new partnerships with local nonprofit partners that serve low-income families (e.g., Sarasota Housing Authority, St. Martha's Church, Children First, Salvation Army, and Hope4Communities).

Challenges, Successes, and Lessons Learned

Many of the challenges noted in the various collaborations on safe, stable, affordable housing in Sarasota County are common initial challenges for multisector partnerships. As Ms. Kane describes, these ranged from groups not having worked together previously; time and effort needed to meet with and establish relationships with various nonprofit organizations; figuring out how to best make an impact given the needs of the community; understaffing; and working with volunteers.

Despite these challenges, they have been able to make significant strides through their energy upgrade and Partners for Green Places programs, and to establish good relationships with partners such as the Sarasota Housing Authority, leading to an additional grant to expand their existing program.

One of the key factors in the successful collaborations between the Planning and Development Services Department and the Department of Health is the ongoing communication between Mr. Henry and Mr. Osterhoudt. They have ongoing communications and discussions, both formal and informal, about how to advance affordable housing in Sarasota County, especially about where to locate facilities (e.g., not in a food desert). They also strive to ensure that there are outdoor activities and amenities for community members to interact with one another. Having an urban planner on staff in the local health department, who engages in anything around planning, is also critical to a successful partnership.

Mr. Henry also notes that successful affordable housing efforts require advocating for the consideration of transportation safety and walkability, underscoring the intertwined nature of initiatives to improve population health, and the need for partnering with multiple sectors within and across governments.

Additional Information

- Sarasota County Planning and Development Services, Affordable Housing
- UF/IFAS Extension and Sustainability

Interviewees (December 19, 2019, February 14 and 28, 2020):

- Chuck Henry, Health Officer, Department of Health in Sarasota & Director, Sarasota County Health and Human Services
- Sara Kane, Sustainability Program Supervisor, Sarasota County UF/IFAS Extension and Sustainability
- Matthew Osterhoudt, Director, Planning and Development Services Department, Sarasota County

Case Study - Substance Misuse/ Prescription Drug Overdose: Hennepin County, Minnesota

Jurisdiction and State:
Hennepin County, Minnesota

Square Miles:
554 square miles

Population:
1,265,843 (July 2019)

Population Density:
2,082 people per square mile

Urban/Rural Classification:
Urban

Poverty Rate:
10.3%

Median Income, 2014-2018:
$74,113

Local Health Department Annual Expenditures:
$65.9 million

Scope of Activities and Implementation

Hennepin County—home to Minneapolis as well as a mix of suburban and rural areas—is the largest county by population in the state.

The county's response to the opioid crisis involves multiple internal and external collaborations, all based around a strategic framework and adopted action plan. That commitment is personified in an opioid response coordinator who leads this county-wide initiative. It also extends to an advisory committee of partners and stakeholders, such as human services, child protection, public health, medical examiners, addiction medicine physicians, sheriff's office, public safety, and substance use disorder treatment providers. Staff hold listening sessions with the advisory committee, as well as a more formal steering committee of 15 to 20 internal staff who meet quarterly to guide implementation.

Motivations and Catalysts

The impetus for action was a decision by the county board in 2017 to adopt a countywide initiative to address opioids, with the public health department designated as the lead agency.

This effort began with the convening of a panel of 42 stakeholders, recognizing that the issue transcends departmental or agency silos. The resulting comprehensive opioid strategic framework specified 32 action items outlining what each department can do and how they can work together. Once the board approved the framework, there was a "now what" moment, at which point the department pursued the hiring of a program coordinator to implement the plan.

The opioid response coordinator, Julie Bauch, was hired in 2018 to do cross-sector and interdisciplinary work across the county on the opioid crisis.

One obvious challenge facing the effort was that it was not provided its own budget. While there was a coordinator and one support staff person, any work they planned to do would need to depend on funds that were dedicated to the task by the various departments involved. To reinforce the partnership aspect of the work, the opioid response staff would often assist those other departments in applying for grants that could support their involvement.

And while there was general agreement on the devastating effect of opioids on the community, there was sometimes disagreement over the appropriate methods of addressing it. As one example, at the time of the coordinator's hiring, the sheriff was not in favor of the portion of the strategic framework that called for medically assisted treatment for opioid disorder in the jail setting. As a result, while those being held in the county jail were offered the narcotic-reversal agent Narcan upon release, they received no medical treatment during their incarceration. Since that time, and following some turnover in the sheriff's department, all incarcerated people of the jail or county workhouse now undergo an evaluation for substance abuse disorder, and addiction treatment with Suboxone can start immediately. When inmates are discharged, they are connected to a community clinic that can continue their Suboxone regimen.

Partners and Champions

Perhaps the department's strongest partner on general public health issues is the Hennepin County Medical Center (newly rebranded as Hennepin Healthcare), the local safety net provider and Level I trauma center. While Hennepin County has a close working relationship with the medical center and other stakeholders, there was no hierarchical chain of command dictating how such work was to progress.

Still, the opioid response coordinator characterized her work with the physicians and administrators at the medical center as a close partnership, as is the involvement of the elected officials and staff of the City of Minneapolis, and researchers, experts and others at the University of Minnesota. Additional partners include the state departments of health and of human services and a myriad of neighborhood community associations, foundations, and nonprofits. Her role is often to bring those groups to a common table for discussion of their priorities and the support they need to accomplish their goals.

Beyond the medical center, practitioner outreach also includes work with medical and dental offices around prescription practices. Through the regional medical examiner's office, statistics on overdose deaths in Hennepin, Dakota, and Scott counties are all reported to the Hennepin County Sheriff's Office. These two actions form two additional links in ensuring the right data are available for informed decision making. This work is also supported by a data science and evaluation specialist who created interdisciplinary data integration across departments.

Two examples of local government partnership efforts are with the cities of Bloomington and Minneapolis. In Bloomington (population 86,000), the city police department works with a county social worker who operates from the police station. The two agencies share mapping technology to track hotspots of substance use or overdose. When there is a neighborhood in need or a specific call for service, police personnel respond; assess the situation; and, if the situation is deemed safe and there is need for social worker support or behavioral health intervention, they dispatch them accordingly. The social worker remains under the supervision of the county but is dispatched directly by Bloomington Police.

In Minneapolis, there are no such ongoing joint staffing arrangements, but there is a clear line of communication. So if the mayor, council, or policy staff have an idea for child protection or another service that's intertwined with county operations, they reach out to their county counterparts to work out the details and see how they might each support such an initiative, even without sharing data that might violate the families' privacy. While Minneapolis does not yet have its own opioid response coordinator, the city has convened a community-led task force that has brought such recommendations forward for consideration.

Medication drop boxes are another collaboration example that is now being implemented countywide. This collaboration involves the county Environment and Energy Department (Public Works), which installs the drop boxes, as well as the host communities (e.g., Brooklyn Park), and the sheriff's deputies who collect the medications from the 55 drop boxes around the community and transport them to an appropriate waste disposal facility. If Environment and Energy suggests five more boxes, they'd meet with the sheriff's office to discuss how that might impact deputies' time to conduct medication pickups. Such discussions are generally an informal negotiation, with the opioid response coordinator facilitating or assisting to investigate funding options.

County Human Services is also partnering with the court system on a diversion program for individuals with first-time drug charges. The social worker/chemical health counselor completes assessments and makes recommendations and referrals for treatment. Human Services has partnerships with the Sheriff's Office and the Department of Community Corrections and Rehabilitation (DOCCR). The Integrated Access Team (IAT) is a team of social workers who work closely with the Sheriff's Office, Hennepin County Medical Center (HCMC), courts, and others.

Overall, what partners have appreciated most is the fact that the county is listening. This is particularly the case in that the neighborhood communities where most nonprofits are based do not have a single demographic, cultural, or substance use profile. Groups within the county such as Somali refugees, Native American urban populations, Blacks, and Whites are each affected by substance misuse in varying ways and having different preferred modes of interaction with service providers. Regardless, in each case, county staff or elected officials are attending their meetings, listening to their concerns, and bringing the communities' ideas back to the opioid response coordinator to craft appropriate harm reduction or public education strategies.

For nonprofit partners that are providing treatment services, that listening might also be paired with lining up referrals for clients in need or with supporting them in their own grant proposals. Having a working relationship with all those treatment providers also helps the county to maintain an understanding of total treatment capacity.

When asked about whether any alternatives to collaboration were considered, Ms. Bauch said, "No, you can't go on your own. Agencies need to collaborate to have an impact." With public health typically one layer removed from direct interaction with the individuals undergoing treatment or entering the criminal justice system, "we need to rely on all community partners to tell us what's going on, ask for exactly what they need, and work together to come up with solutions."

At the policy and procedural levels, the most significant changes have been around referrals and treatment. Both Child Protective Services and the Probation Department are working to streamline client referrals so that treatment can start more quickly. Within the libraries, a pilot project was initiated through which security staff would carry Narcan for emergency overdose reversal. After that program led to 12 reversals in six months, the county administrator has given approval for its expansion, so that security staff in all county-owned buildings now have Narcan available.

The policy issue of the status of Medicaid coverage among incarcerated people remains unaddressed. Federal law says that when you enter a corrections facility, your Medicaid gets cut, then you can reapply after your release. In Minnesota, Medicaid coverage is only supposed to be "suspended," but the existing state computer system does not have a way to differentiate this from a termination of coverage. As a result, if people don't reapply on time when they exit, they may miss treatment or not receive their medications on time, although they should be able to have Medicaid automatically restarted for them according to state law. Currently, there is no planned state software fix to rectify this issue.

More typically, policy decisions are handled as part of the county budget. For example, the Suboxone being offered in the jails is currently supported by a one-year grant. As that funding expires, an equivalent amount has been placed in the sheriff's operational budget to continue the program.

Resources

The start-up costs for the coordination effort consist of the salaries and benefits for the opioid response coordinator and a principal planning analyst (combined salary range $129,000 to $205,000). The analyst position had started out as a part-time post during the strategic framework process and had been expanded to full time in late 2019, with funding provided through the information technology budget.

There is no operating budget to cover outreach, public education, or referrals. All such activity is either carried out by the two program staff or the various internal or external partners' operational budgets, or is funded by grants.

Measuring and Evaluating Outcomes

Program evaluation is led by the analyst and by an epidemiologist within public health. Statistics on overdose rates, emergency room visits, and other indicators will be shared via an upcoming opioid data dashboard.

Through the medical center, there is also a physician researcher who has grant funding to work on evaluation of any health-related interventions. Most initiatives began in mid-2019, and concrete data available on program results have yet to be collected.

Recidivism rates are being tracked through the court system, but at this stage, results are not yet available. Statistics aside, conversations between the court staff and the program coordinator help inform in-jail treatment and inter-agency collaboration.

Community engagement and feedback mechanisms have started in 2020, such as regarding the community nonprofit outreach and the Narcan distribution and syringe exchange clinics.

Among other program results, a new six-person opioid executive committee of county administration decision makers was launched in 2020 with goals of facilitating access to treatment and working toward financial sustainability of the program, so that in five to 10 years, they will have a solid, integrated plan within the budget that no longer relies upon time-limited grant funds.

Challenges, Successes, and Lessons Learned

A positive surprise about this collaboration has been how readily and effectively all the stakeholders have worked together. One area where efforts are still ongoing is engaging with the educational sector. With limited staffing, budgetary constraints, and resistance from some schools, Hennepin County has yet to launch a school-based curriculum but is hoping to assemble a team and start working with a few interested sites within the next school year.

Offering advice to those who might be considering such a collaborative model, Bauch recommended building the internal stakeholder relationships before getting started with the outside community. Doing this gave her a better understanding of what the county

could do and what its limitations are. That way, when she goes to the community, she can communicate exact resources and limitations, advocate on what steps they can take, and work to build a relationship of trust and transparency.

Considering the replicability of this approach outside the state, she also feels that local communities' tradition of trust in government, faith-based organizations, and other nonprofits has aided in their roll-out. Where that trust doesn't exist, organizations may be more likely to try to implement new programs on their own and miss out on the larger community benefits to be achieved though collaboration.

Additional Information

- Hennepin County opioid data dashboard
- Hennepin County website, "Get help with an addiction."

Interviewee (December 18, 2019):

- Julie Bauch, Opioid Response Coordinator, Hennepin County

Conclusion

This report examined how multiple local government agencies are collaborating to help address today's greatest public health challenges and the role that public health agencies play in these partnerships. Using a combination of survey results from chief administrative officers and case studies of three diverse jurisdictions engaged in cross-sector collaborations to address healthy community design; safe stable, affordable housing; and substance misuse/prescription drug overdose, the report provides information and promising practices to elected and appointed leaders and public health officials.

As jurisdictions consider whether and how to engage in cross-sector collaborations to improve population health, several key takeaways emerged:

Build strong internal relationships: For a cross-sector collaboration to be successful, building strong internal relationships and making sure that those are in place before reaching out to the wider community is critical. This can include making sure you have "the right people at the table," building trust between partners that may or may not have collaborated before, and making efforts to come up with a shared language, rather than agency or industry-specific jargon, for how to speak about the topic of collaboration.

Obtain leadership support: For a cross-sector collaboration to get off the ground—and for it to be sustainable—organizational leadership must support the efforts. This can take the form of allocating specific resources, such as funding or staff time. Alternatively, it can mean providing a supportive environment and/or modeling collaborative approaches to problem-solving more generally.

Find program champions inside and outside of public health: It is possible for local units of government, including non-public health professionals, to be the leaders of cross-sector collaborations that focus on improving population health. Those local champions outside of the public health department embrace the same priorities and can play (or are already playing) that leadership role. This is especially the case for land use policies and infrastructure investments, many of which are made at the municipal level.

Communicate clearly and regularly with stakeholders: Because clear and ongoing communication with both internal and external stakeholders may seem obvious, it may be overlooked when working on cross-sector collaborations. The communication can be informal or formal, but it should be ongoing. There should be clear parameters as to when and how information is being communicated and what the expectations are for each partner in the collaboration.

Engage the community with trust and transparency: Once strong internal relationships are in place, collaborative partners should reach out to the broader community, both to tell them about the partnership, and to listen to input, especially needs and concerns. It is important that the community has a clear understanding of available resources and limitations, know when and how any feedback will be collected, if/how the program will be evaluated, and if/how those results will be shared. This sets expectations and encourages engagement by building trust with the broader community and exhibiting transparency.

Whether addressing long-standing public health challenges like ensuring that communities have clean drinking water or responding to new threats like the COVID-19 pandemic, cross-sector collaborations have the potential to help multiple local government agencies combine their resources and expertise to improve population health. When done successfully, these partnerships break down silos and reduce inefficiencies, enabling local governments to protect and promote the health and well-being of all communities.

Additional Resources

How Does the Public Health Workforce Compare with the Broader Public Sector?, Center for State and Local Government Excellence, March 2020, https://slge.org/assets/uploads/2020/03/public-health-workforce.pdf

Improving Quality of Life: The Effect of Aligning Local Service Delivery and Public Health Goals, ICMA, https://icma.org/sites/default/files/308297_Improving%20Quality%20of%20Life%20Report%206-23-16.pdf

"Shared Staffing in Public Health: Collected Resources," Center for State and Local Government Excellence, https://slge.org/resources/shared-staffing-in-public-health-collected-resources

End Notes

[1] Robert Wood Johnson Foundation Commission to Build a Healthier America, *Time to Act: Investing in the Health of Our Children and Communities*, 2014, available at https://www.rwjf.org/en/library/research/2014/01/recommendations-from-the-rwjf-commission-to-build-a-healthier-am.html

[2] Paul W. Mattessich and Ela J. Rausch, *Collaboration to Build Healthier Communities: A Report for the Robert Wood Johnson Foundation Commission to Build a Healthier America*, 2014, available at https://www.rwjf.org/en/library/research/2013/06/collaboration-to-build-healthier-communities.html

[3] Note: Functions like planning/development and administration are listed as both internal and external partners, reflecting that these functions may exist in more than one agency.

[4] Center for State and Local Government Excellence, *Innovations in the Health and Human Services Workforce*, 2019, available at https://slge.org/resources/innovations-in-the-health-and-human-services-workforce

[5] City of Arvada, *Comprehensive Plan 2014*, September 16, 2014, available at https://static.arvada.org/docs/Arvada_2014_Comprehensive_Plan_(Full_version)-1-201706071308.pdf

Successful Collaborations Between Local Government and Public Health: Exploring Multisector Partnerships to Improve Population Health

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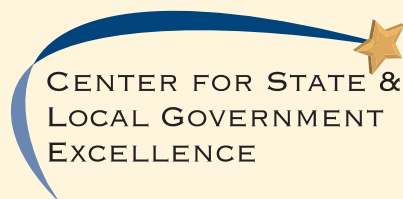
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