Community Partnering for Behavioral Health Equity: Public Agency and Community Leaders' Views of its Promise and Challenge

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Objective: To understand potential for multi-sector partnerships among community-based organizations and publicly funded health systems to implement health improvement strategies that advance health equity.

Setting: In 2014, the Los Angeles County (LAC) Board of Supervisors approved the Health Neighborhood Initiative (HNI) that aims to: 1) improve coordination of health services for behavioral health clients across safety-net providers within neighborhoods; and 2) address social determinants of health through community-driven, public agency sponsored partnerships with community-based organizations.

Design: Key stakeholder interviewing during HNI planning and early implementation to elicit perceptions of multi-sector partnerships and innovations required for partnerships to achieve system transformation and health equity.

Participants: Twenty-five semi-structured interviews with 49 leaders from LAC health systems, community-based organizations; and payers.

Main Outcomes Means: Grounded thematic analysis of interview data.

Results: Leaders perceived partnerships within and beyond health systems as transformative in their potential to: improve access, value, and efficiency; align priorities of safety-net systems and communities; and harness the power of communities to impact health. Leaders identified trust as critical to success in partnerships but named lack of time for relationship-building, limitations in service capacity, and questions about sustainability as barriers to trust-building. Leaders described the need for procedural innovations within health systems that would support equitable partnerships including innovations that would increase transparency and normalize information exchange, share agenda-setting and decision-making power with partners, and institutionalize partnering through training and accountability.

Conclusions: Leaders described improving procedural justice in public agencies' relationships with communities as key to effective partnering for health equity. *Ethn Dis.*2018;28(Suppl 2):397-406; doi:10.18865/ed.28.S2.397.

Keywords: Community Partnering; Procedural Justice; Health Equity; Care Coordination; Behavioral Health

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Introduction

Partnerships between community-based organizations, social service agencies, public health researchers, health policymakers, and safety-net providers constitute a promising strategy to develop and implement health and health care improvement strategies that can achieve health equity.[1-5] Broadly speaking, health equity has three aims: to promote equitable access to health-related opportunities when needs are equal (horizontal eq-

uity); to provide enhanced opportunities when needs are greater (vertical equity); and to address the systems and societal issues that perpetuate inequalities.[6,7] Public systems often have gaps in coordination across general medical, behavioral health, and social services that impede access and undermine efforts to address prevention and the social determinants of health.

Many health equity reforms emerging across the country use multi-sector partnerships to address social determinants of health at the neighborhood level,[8] coordinate

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health care systems for high-risk beneficiaries, and/or strengthen formal linkages to social and other community-based service organizations.[9,10] Both Medicaid's health homes programs[11,12] and the Accountable Health Communities Model (AHCM),[13] announced by the Center for Medicare & Medicaid Innovations in January 2016, help providers and hospitals link Medicare and Medicaid beneficiaries to social services that may help

address unmet health-related social needs. Municipal governments have also adopted approaches that aim to strengthen partnerships across health and social service sectors, such as the ThriveNYC initiative,[14] which will invest $850 million over four years to target prevention and early identification of behavioral health conditions.

The Los Angeles County (LAC) Health Neighborhood Initiative (HNI) features the use of partnerships to improve care coordination and address social determinants of health. The HNI pursues a mission of "strengthening the community's capacity to support recovery and resiliency" through: 1) improved individual services coordination and linkages across behavioral health agencies; and 2) partnerships with communities to enhance service access, coordination, and quality while improving outcomes for community, consumer and family-prioritized social risk factors such as housing security, employment, safety from violence, educational achievement, and other community-prioritized outcomes.

While community partnering appears to be a powerful strategy for achieving health equity, the success of the HNI approach will depend upon implementation efforts that may be driven by perceptions of involved public agency leaders toward community partnering. In this article, we use interview data collected during the early planning and implementation phase of the HNI to identify the potential for partnerships to further the aim of health equity. Data address how public health agency leaders understand the potential risks and benefits of multi-sector partnerships,

the barriers and solutions involved in making public-community partnerships work, and the innovations that would be required for partnerships to achieve their full potential for system transformation and health equity. In particular, we highlight the ways in which public health leaders identify process innovations as critical to the success of multi-sector partnerships. We conclude that process concerns are critical areas for further study and pose additional empirical questions for study as health equity reforms unfold.

METHODS

Context

The LAC Board of Supervisors added the HNI to the LAC Strategic Plan in 2014 to transform the delivery of behavioral health services and improve population-level behavioral wellness through neighborhood coalitions and community engagement. HNI was inspired by the Community Partners in Care (CPIC) study, which used a cluster-randomized controlled trial to compare two approaches to implementing expanded collaborative care, a partnered strategy vs a technical assistance strategy, in two predominantly minority, under-resourced communities in LAC.[15-17] CPIC's partnered approach, called Community Engagement and Planning (CEP), emphasized power-sharing through two-way capacity building, respect for diversity, community wisdom, use of evidence-based practices, an asset-based approach, and transparency to promote equal authority among partners in all phases of a project.

As in CPIC, partnerships were developed within a geographic area (ie, a health neighborhood [HN]) to link physical and behavioral health care systems with non-traditional and trusted community members (pastors, park employees, teachers) who would provide preventative programs and facilitate early detection and referral to treatment. Without dedicated funding, HNI goals were embraced by the integrated LAC Health Agency that aligns activities of the Departments of Health Services (DHS), Public Health (DPH), and Mental Health (DMH). In fiscal year 2014-2015, Health Agency leaders identified at least one HN within each Service Planning Area (SPA) (eg, El Monte in SPA 3) based on the availability of potential partners and other factors. Multi-sector coalitions within health neighborhoods to address behavioral health care coordination began meeting in mid-2015.

Study Participants

We sought to enroll and interview a diverse group of agency and community leaders across LAC who would play a pivotal role in HNI implementation. We first recruited and enrolled all leads of LAC's eight geographical SPAs as well as five heads of major divisions within the LAC Health Agency's DMH. Many of these leaders invited their deputies to participate. We then recruited and enrolled all four DPH leads of service areas as well as five leads of DHS divisions involved in public or system-wide outreach or engagement. Next, to clarify the community context, we recruited leaders from community-based organizations (CBO) and from

Table 1. Interview participants

Organization	Number of Interviews	Number of Participants
DMH[a]	11	23
DPH[a]	6	13
DHS[a]	4	6
CBO	2	3
Other government/payer	2	4

a. Departments within the LAC Health Agency
DMH, Department of Mental Health; DPH, Department of Public Health; DHS, Department of Health Services; CBO, Community-based organization

other non-health government agencies working closely on HNI goals. We targeted representatives from CBOs mentioned by Health Agency leaders for their work with key HNI constituent groups (eg, children, individuals with mental illness, homeless). One MediCal insurance payer organization serving LAC was also recruited. One of the five targeted organizations recruited for interviewing did not respond to requests for an interview. Our final study participant group included 49 stakeholders (hereafter called "leaders") who usually participated in interviews in groups of 2 or 3 for a total of 25 interviews. (Table 1)

Procedures

We conducted the majority of our interviews between June and September 2015 during the early planning and implementation stage when few formal HNI-related partnerships existed. Though our data do not describe implementation progress in 2015-16, HN coalitions grew considerably during that period. By August 2016, eight HN coalitions had engaged representatives of 246 agencies from multiple sectors. One-hundred thirty-four health providers, payers, and community organizations (eg, faith-based, WIC, housing, transportation) had

signed memoranda of understanding (MOUs) to formalize collaborations.

Two to three interviewers conducted semi-structured 60- to 90-minute interviews in-person or by telephone with each stakeholder. Stakeholders were asked about the HNI, including key facilitators and barriers to implementation of community engagement in the HNI. All interviews were audio recorded and transcribed verbatim. Transcripts were edited to remove names and other identifiers to secure participants' anonymity. Transcripts were sent securely to participants for review. Participants made minor edits or clarifications to transcripts. The study protocol was approved by the RAND Human Subjects Protection Committee and the LAC Department of Mental Health Human Subjects Research Committee.

Data Analysis

We used a grounded thematic approach to data analysis to develop theoretical insights about the potential impact of multi-sector partnerships on health equity. We coded transcripts using an open coding approach in Dedoose, a qualitative data analysis software. Open coding refers to the process of breaking the data apart into blocks of text that sum-

marize one category of information. One coder conducted open coding then two coders (CF, EB) conducted axial coding, relating concepts emerging from open coding to each other to develop a matrix of categories of information.[18] We sought to relate text segments that described perceptions of risks and benefits of partnerships, barriers to partnerships and corresponding solutions, and strategies required for partnerships to achieve their full potential. A preliminary set of axial codes was developed by one coder and all coded text segments were reviewed by a second. Discrepancies were debated and codes and subcodes were distinguished. Both coders then applied the revised set of axial codes and subcodes to the data, each coding about half. All authors reviewed initial findings (codes and text segments) and discussed and reconciled discrepancies using cross-case comparison. Five inter-rater reliability tests were then conducted on 18% of the data (99 of 543 excerpts), with Cohen's kappa coefficients ranging from .3 to .7. The two coders then summarized text segments within each code and subcode, elaborated themes that captured patterns, and identified key quotes for each theme.

Interpretations were refined through member checking, also known as informant feedback or respondent validation.[14] Member checking consists of sharing findings with participants and incorporating their feedback to improve the accuracy and credibility of findings. Preliminary findings were shared with small groups of community and health agency leaders on two occasions and feedback was incorporated.

Then, drafts of the findings were sent to three leaders familiar with all stakeholder groups sampled. Two of the three leaders reviewed results and provided detailed insights to refine interpretations. Both leaders had extensive experience in HNI planning activities and community partnership but only one in CPIC, increasing the range of insights offered.

RESULTS

Transformation Through Partnership

Broadly speaking, all interviewees endorsed the promise of multi-sector partnership in public health. They perceived that partnerships would improve access to scarce resources, thereby supporting health equity. And, in ways we describe below, many leaders perceived a partnered approach as potentially transformative for health systems. As a leader (DMH) said: "…our current challenge is finding a way to get … a system-changing project rather than merely another nice LA pilot project." This leader continued with the hope that, through HNI, partnerships aimed at improving care coordination and bringing communities together to address social determinants could "really change the nature of the system."

While CPIC had taken place in only two communities in LAC, the partnerships forged in CPIC instilled confidence and operational expertise in those leaders who had participated. As one leader (DPH) with CPIC experience said, the "planning process made a lot of sense" because "I was involved in CPIC … and they've

been doing this for…10 years." Another leader (DMH) commented that the planning process for HNI began with the provider community; but, citing the CPIC approach, "I'm wondering if it would have benefitted us to start more at a grassroots level… so that it would have been more inclusive and we would have gotten lots of input and feedback." Many leaders perceived that HNI borrowed features from CPIC, including a focus on community-driven goals and shared decision-making.

Leaders articulated both promising and challenging aspects of partnering. Leaders worried that limited resources and questions about partnership sustainability could undermine HNI. Most frequently, leaders identified the need for new processes that would support relationship-building and sharing of agenda-setting power in order to further health equity through partnership. In what follows, we describe each theme with key examples from interview data.

The Promise of Partnering

Leaders from all sectors recognized multiple benefits that would accrue from partnerships between and among community and public health agencies. For instance, leaders recognized the importance of partnering for shared clients. As one leader (DMH) said, "we're pulling together providers for mental health, health and substance abuse. The whole idea is to see if they can work more closely, collaboratively, sharing information, treatment plans for the clients." This leader talked about the informational gains from cross-sector partnerships by stating that providers "just have

not been aware of what actually is available in the community." Increasing collaboration was understood as an important way to improve access to care. Leaders also saw partnerships as a way to advance their ability to reach organizational goals. As one leader (DMH) said, an initial task was identifying capacities but then "How can that agency help us do, [help us] to get our mission accomplished? And vice versa." Leaders also mentioned goals of managing scarce resources through improved collaboration. As one leader (DMH) said, "Everybody is short on resources," and "the need is huge, and I think that most providers want to coordinate, because that's how they maximize their services."

Leaders also described transformative goals of building shared values and agendas. One leader (DPH) said HNI is about more than asking "where's the redundancy [but instead] how do we leverage toward synergy and how do we complement rather than spin our wheels on duplication within [a community]" where there are "a number of really well intentioned organizations out there doing some good stuff." Another leader (DMH) described that, in her community, partnerships had helped to build "common goals" and "common ways of communication."

Other leaders thought partnering held promise beyond health care delivery. As one leader (DHS) said, HNI has "the aim of improving some of the health of the communities here through bettering the various resources, whether they be health resources or community-based organizations like churches. Really looking for a way to harness all those resources to improve

the health of the community and engage the community in that process." Another leader (DPH) talked about the ability of partnerships to "help connect the pieces" for community organizations because a partnership with a public agency "re-energizes the work they're doing because…they've lived it but to see that other people - academics, government - recognize that that is true, I think that's been a huge benefit [by] showing the legitimacy, helping them construct the story so they can talk to other people, especially funders." In these ways, leaders understood partnerships to be not only a means of increasing efficiency and the quality of service delivery but also of achieving fundamental health goals for a community.

The Challenges of Partnering

In describing challenges, leaders frequently reflected on the need to build trustworthy partnerships. One leader (DMH) felt that "the trust issue" was particularly important because of frequent experiences in some communities that "the government comes in, and they say they're going to do something. But they don't really do it;" moreover, "the more fearful part is that if they enter a government service, they might find out that they're undocumented." This leader saw trust building as a first step: "I think that people have to know that this government-funded project can help them and can support them." Another leader (DMH) recommended demonstrating trustworthiness: "someone…picks up the phone and [the caller can say] 'hey, I got a response' -- and there's that consistent communication of 'you can

depend on me to follow up on this.' It's little things like that that have a large impact." Another leader (DHS) said succinctly "I think relationships are the most important thing."

Leaders described this work as time-consuming and risky if not done well. As one (DHS) said, "the exhausting part, because it takes a long time, is trust building. It's going to take a while." The leader warned that you "have to plan to not have a ton of tangible programmatic progress because it does take time." Another leader (CBO) said that, to enter into partnership, agency staff would need to "research the neighborhood and figure out what the best entrance is into" the coalitions and "that is not going to be an easy thing." An overriding concern was the potential for disappointing community groups and individuals. Leaders said that communities needed real solutions, not opportunities for building relationships; as one leader (DMH) said, community groups "don't come asking questions like, 'What do you guys do?' They are coming in with problems they are dealing with in their community."

Leaders cited limitations in service capacity as a barrier to partnering, one that one leader (DMH) said was "right in front of our eyes." This leader summarized, "to the degree that we can be supportive by bringing in our existing programs, by saying, 'Here's a program…come and take this,' that's good. To the degree that [community groups] say 'here is a need that we have that you have no program for,' that's a challenge." Leaders recognized that these resource shortages could undermine trust-building. As

a (DMH) leader said, "Basically they have to know they can count on us." This leader told the outreach team to "never promise them something you can't deliver." When presenting a list of services, in other words, the leader expected community groups to ask, "'What do you actually provide? Who do you actually provide it to? If we call for this, can we actually get somebody in?' And I don't think we'll have any community credibility until we get that down." Two other leaders added that, to build partnerships, health agencies had to clarify that they were not asking community groups to fill service gaps; one leader (DMH) imagined this response from community groups: "Please don't ask us to do your work."

Sustainability was a final concern, because, as one leader (DMH) said "the community is justifiably angry at us when we do things that [we] can't follow through." Leaders stated that beginning and then abandoning programs would further undermine community trust. They named building in overlapping types of support for programs, finding champions in the community, and supporting community organizations as strategies for sustainability. One leader (DMH) summarized these strategies as ones that rely on non-monetary resources by stating, "We need to think about how whatever we're creating is sustained, and if the answer is we need more money, it's not a good answer."

Revamping Bureaucracy for Partnership

According to leaders, the central challenge of partnership was the operational style of health agencies

themselves. Leaders indicated that health equity reforms like HNI required process innovations within public health agencies that would allow new ways of building and sustaining relationships, sharing power, and normalizing partnership as a component of everyday work. In their view, such a process innovation would allow for new forms of responsiveness and reciprocal engagement between government agencies, with an ability to address a broader array of issues than traditionally under the purview of public health agencies.

For instance, leaders hoped that partnerships could decrease the opacity of others' processes and instantiate new norms for communication and collaboration. Some described siloes as undermining care coordination, as this leader (DMH) explained, "the mental health providers didn't necessarily understand how the physical health provider side worked." Another leader (DMH) commented that "people inevitably work in silos and I think, that's our biggest downfall." This leader described "being able to pick up the phone or send an email… and dialoguing and saying, 'hey…this is what's happening with so and so and I know he goes there…and blah blah blah.' And just kind of working in that type of a fashion, I don't think we've really developed that process." Many leaders hoped open communication could come to characterize relationships of all types. As one (DPH) said, community is "almost like another silo….There's Public Health, there's Mental Health, there's Health Services, there's CBO's, and then there's community members and for different reasons we all operate in our

silos." Another (DMH) agreed that, "the biggest challenge will be getting people to see this communicative process, [this] coordinating process, as being more of the standard."

Second, leaders felt they lacked norms and procedures through which to share power with community groups and members. Leaders saw a need to include community groups in agenda-setting through dialogue yet perceived government processes as proscriptive and directive. As one leader (DPH) said, "We tend to want to see ourselves as experts. We've got all this knowledge. We've got our data and best practices. We want to feel prepared when we go out in the community and we get in this pitfall where…so partnering with them to develop a plan, we're going to be nice all smart [*sic*] and develop this plan and give it to the community and it's easy to fall into that." Instead, in partnership, as another leader said (Other Government agency), "the number one barrier is… the willingness to share the space with others so that we're all working together. …And then trusting that the community has the answers." Another leader (DMH) agreed that community groups "don't want to be told; they want to have a voice. That is why I'm very afraid of showing up with a group of them to the meeting. Because we tell them [what they want], and [in contrast] they are very clear about what they want." Similarly, many leaders commented on the disjunction between the decision-making procedures required within public agencies and those that would be welcoming to community groups. One leader (DMH) perceived that community

leaders might be alienated by the technical and hierarchical structure of Health Agency meetings where top-down decision-making and task delegation are the norm. "I don't want to bring community members to these meetings, because we'll lose them for sure. The meetings are very formal, and we talk about MOUs, and papers that people read. Community members are not interested in that."

Leaders voiced another concern: potential non-overlap between community groups' and agencies' interests and agendas. For instance, one leader (DMH) explained that DMH's "primary focus is on working with the severe and persistently mentally ill. … In terms of our grassroots members, our community members, their issues may not rise to the level of severity but having someone to talk to." Leaders were attentive to the need to have activities germinate and grow within the community itself, which meant placing the agency's agenda in the background. For example, a leader (DMH) said, "I think if we do our job well and we do construct a health neighborhood," the coalition's agenda "isn't our call. I think that's the community's call. I think that we can't put this idea [out] that the community should be directing itself" to address a particular problem. Nonetheless, leaders were not always certain they would have the authority to assist the community groups with their identified priority.

Several leaders described partnership as an activity that would have to happen outside of official channels. Leaders talked about taking off their "agency hat" to meet community groups or using strategies that relied on the individual creativity of the leader. One leader (DMH) had not yet asked community groups to invest in HNI because "we haven't met [community groups'] needs [and] I don't have the ability to bring in the resources" to serve particular clients in the neighborhood. The leader continued that "I'm not taking them to those [HNI] meetings … because then I lose my credibility. I take them to what they hate – which is the bureaucracy." As another leader (DPH) said, "theoretically we all have … an understanding that we need to partner with community and we need to collaborate, but how to actually do that, I don't think that's either in our training … or in our organizational structure." This individual wished health agencies could offer "proper training tools" and a "performance goal" tied to partnering, not just an "informal expectation that you collaborate." The leader concluded that, "until there are really tools or accountability built into the bureaucracy, it is not going to be effective."

DISCUSSION: LESSONS LEARNED

In this study, we examined the translation of a community partnered research project into public health policy and practice in Los Angeles County. The public agency and community leaders we interviewed were deeply invested in the mission of building cross-sector partnerships in order to achieve health equity. They cited the importance of trust and adequate resources to the success of partnerships, and they saw the benefit of furthering transparency through relationships. Partnerships were understood as generating substantial benefits directly and through their ability to energize and tap into existing strengths. Interviewees were interested in aligning available resources to the needs and processes of community. These findings are particularly notable because 42 of our 49 interviewees were administrators or policymakers from health agencies (ie, LACDMH, DPH, or DHS), a group not usually perceived to be a constituency for community partnership.

Most theoretical frameworks for understanding community partnering emphasize the role of partnerships in altering community empowerment or capacity.[19-21] For instance, Empowerment Theory emphasizes that partnerships may address inequities through their impact on community members' ability to be active in improving their organizations and communities,[22] while Community Capacity Theory[23] describes partnerships as boosting capacity[24] to build sustainable community change. In contrast, our interviewees assumed strengths within their communities. They identified procedural problems within public agencies as barriers to partnership – and as potential areas for change *via* partnership. These procedural changes were also seen to be the source of public health system transformation and an engine of health equity.

For example, leaders sought to find new spaces and procedures through which to incorporate community members' voices. In their descriptions of silos that diminish understanding of others' work, stake-

holders said that the success of a policy would rest on process innovations that normalized collaboration and communication. They also lamented that public health agencies' priorities can be narrower than communities would prefer, such as in focusing on treatment of severe mental illness rather than supportive counseling. Ideally, they said, the process innovation would allow community and agency

> *…as leaders suggested, these guidelines for achieving procedural justice may apply to relationships between and within public agencies as much as to relationships with communities.*

leaders to develop a shared vision that focused on a novel mission developed collaboratively. CBO and non-health agency leaders indicated that this would require trusting the community to bring answers to the table. Many interviewees noted that bureaucratic procedures can disadvantage certain groups and function to maintain the *status quo.* They described the use of jargon and top-down norms and agenda-setting as features of meetings that can not only undermine inclusion of community voices but also shape resource allocation. These findings are consistent with conclusions

of the World Conference on Social Determinants of Health that participatory processes and transparent, meaningful collaborations are critical to reducing health inequities.[25]

In these ways, leaders suggested that procedural justice is a key barrier to community-public partnering for health equity.[26] Procedural justice entails "equitable processes through which low-income communities of color, rural residents, and other marginalized groups can gain a seat at the table—and stay at the table, having a real voice in decision making affecting their lives."[27, p81] Ensuring procedural justice means that individuals have the right to be treated as an equal and to be given equal concern and respect in decision-making. Increasing democratic involvement and control, practicing inclusiveness and representation, parity, and open communication are all ways to improve procedural justice. Procedural justice includes not only that all groups are treated fairly in decision-making but also that they perceive the procedures leading to decisions to be fair.[27]

Describing procedural justice, Tyler[28] identified three characteristics of a process that strengthens relationships between communities and public agencies: 1) Neutrality, or the belief that public agencies have created a level playing field; 2) Trust, or the implicit belief that relationships are for the long term and can be relied upon, thereby creating loyalty; and 3) Standing, in which interpersonal encounters are characterized by respect and dignified treatment. Other work has identified that the distribution of control is key in shaping people's belief in a particular process and

their support for its outcomes.[29-31] Tyler and Blader[32] suggest that, in order to nurture fairness and trustworthiness between communities and public agencies, authorities should ensure that community members are given a voice within a process[31] and are treated in ways that encourage cooperation. This echoes leaders' attention to trust and reciprocity. And, as leaders suggested, these guidelines for achieving procedural justice may apply to relationships between and within public agencies as much as to relationships with communities. Interviewees suggested other strategies for ensuring procedural justice: sustained funding, training, buy-in from leadership, accountability, and clarifying expectations and limitations.

These findings also highlight keys to translation of academic research into health policy[9,33] and practice. CPIC influenced policy in ways beyond adoption of an evidence-based intervention. Leaders described learning strategies for effective community engagement from participation in CPIC and gaining inspiration to try novel approaches to improving health. CPIC's success in addressing depression care was understood to have potential applicability to other types of problems, including social determinants of health. The evidence generated by CPIC provided assurance that a partnered approach could be effective. Finally, relationships between academic, community, and policy leaders developed in CPIC helped to move HNI forward. This suggests the importance of experiential learning, sustained engagement, and trustworthy relationships to the translation of evidence into practice.[34,35]

These findings have several limitations. They reflect the views of only some health policy leaders and a small number of community representatives in one large county. Health neighborhood coalitions were beginning to form at the time of interviews and key community partners were not yet established, limiting the perspectives we gathered from community stakeholders. We have conducted subsequent data collection with a broader group of community leaders and will use these data to test the utility of the procedural justice framework. Relatedly, this article represents a first description of the evolving HNI story; leaders' perceptions are likely to change over time. In addition, those who participated in the CPIC study may have been more likely to agree to interview. Their descriptions of CPIC's impact may have been influenced by the fact that some CPIC investigators conducted interviews. Member checks were performed with individuals experienced in and committed to community partnering, which may had led to emphasis on the positive potential of partnership. On the other hand, because interviews took place early in the HNI process, uncertainty about the scope and funding of HNI likely shaped leaders' views.

Conclusion

Leaders' perspectives offer lessons for other health equity initiatives such as ThriveNYC and Accountable Health Communities.[13,14] Leaders indicated that training, institutional incentives, and account-ability are necessary to support the work of partnership. In many public health systems, administrative approval is needed to call meetings, with invitation lists and agendas to be posted ahead of time for comment. Our findings suggest that these requirements may erode options for community input and collaborative agenda- setting. Our interview data also indicate that flexibility would be needed in establishing partnership goals. Public agencies often have specific mandates that are not mutable, but processes like partnership require agendas that further community-defined goals that may or may not overlap with this mandate. In these ways, some of the most critical opportunities for improving health equity through partnership may be found with the advance of procedural justice within public health systems.

Author Contributions

Research concept and design: Bromley, Figueroa, Chung, Miranda, Menon, Whittington, Jones, Wells, Kataoka; Acquisition of data: Bromley, Figueroa, Kadkhoda, Chung, Miranda, Menon; Data analysis and interpretation: Bromley, Figueroa, Castillo, Kadkhoda, Chung, Miranda, Menon, Whittington, Jones, Kataoka; Manuscript draft: Bromley, Figueroa, Castillo, Kadkhoda, Chung, Menon, Whittington, Wells, Kataoka; Acquisition of funding: Miranda, Wells; Administrative: Bromley, Figueroa, Castillo, Kadkhoda, Chung, Menon, Whittington, Jones, Wells, Kataoka; Supervision: Bromley, Figueroa, Chung, Menon, Wells, Kataoka

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