Foreword

Lori Freeman, Chief Executive Officer, NACCHO

NACCHO is a proud partner with the Center for Community Resilience, the Centers for Disease Control and Prevention, and the 13 Resilience Catalysts local public health departments sites across the country. Our achievements and learnings throughout our five years of the Resilience Catalysts in Public Health program represent a truly innovative strategy; one that leverages the goals of Public Health 3.0 with the Community Resilience framework to move equity from conversation to measurable action. We stepped into the unknown to learn with and from each other to ultimately demonstrate our collective success with key findings and recommendations to strengthen the Resilience Catalysts program. We also rise by learning from others and putting into practice these innovations that lift up the field. To that end, we invite all of our public health colleagues and community champions to review these evaluation findings and recommendations, and join us in addressing systemic inequities to create more vibrant, resilient communities.

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NACCHO would also like to acknowledge the following people for their work on the Resilience Catalysts Evaluation effort:

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We would like to thank our public health partners from across the country who have participated in the pilot implementation of the Resilience Catalysts. The COVID-19 pandemic challenged America’s public health infrastructure, and yet in the face of widening health and social disparities, our partners remained dedicated to implementing a framework that provided a timely strategy to address structural barriers to achieving optimal health and social well-being. As hundreds of local, county, and state public health entities declared racism a public health issue in 2020, the cohorts of RC were translating declarations into action. In doing so, they demonstrated the potential for a role as Community Health Strategist.

The lessons learned in this report are culled from a multi-year effort to position local health departments and community partners in addressing the multi-generational impacts of systemic inequities. We hope that this evaluation provides guidance on how to strengthen the nation’s public health systems. By collaborating with cross-sectoral and community partners to prevent adversity, participating local health departments have demonstrated a dedication to creating equitable access to supports and resources that will help children and families ‘bounce forward’ and thrive. This is what community resilience looks like. The presence of community-based resources and change in the social and health outcomes produced illustrate how community resilience can be measured across the lifespan.

We thank the Resilience Catalysts network partners and all of the public health leaders across the country who over the past three years have remained dedicated to building a just and resilient nation using a public health approach.

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• Bill Dietz, MD, PhD
  Director, Sumner M. Redstone Global Center for Prevention and Wellness
  Milken Institute School of Public Health, George Washington University
CDC is proud to partner with the Center for Community Resilience, NACCHO, and the larger Resilience Catalyst (RC) network in this important work. The Resilience Catalysts initiative is the first of its kind. This work is crucial in centering community voices and giving them the tools and partners they need to advance equity. By leveraging the trust and credibility we place in public health departments and their reach and scale across the country, this initiative has the potential to make a positive impact on communities throughout America.

We want to acknowledge and honor the hard work and dedication of the individual sites that make up the larger RC network. The guide demonstrates the components of the RC process as well as crucial feedback on how to improve the process going forward. Our hope is that this guide can be used to help inform, empower, and advance communities’ work around resilience.

**Centers for Disease Control and Prevention (CDC) Resilience Catalysts: Technical Assistance Providers**

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The Population Health Innovation Lab (PHIL), a program of the Public Health Institute, conducted this evaluation through the Monitoring, Evaluation, Research, and Learning Innovations (MERLIN) team in partnership with NACCHO, CCR, and CDC.

The authors appreciate the support of the CCR, NACCHO, and CDC teams. We are grateful for the individuals who shared their perspectives with us through surveys and interviews to expand our understanding of RC’s preliminary impact and information implications for theory, practice, and funding in the post-COVID-19 context. Specifically, we would like to express our gratitude to the following 12 local health departments across the United States and their network of community partners, which include community members, coalitions, CBOs, and cross-sector partners:

- Alameda County Public Health Department (CA)
- AppHealthCare (NC)
- Baltimore City Health Department (MD)
- Cambridge Public Health Department (MA)
- Cleveland Department of Public Health (OH)
- Florida Department of Health- Leon County
- Jersey City Health and Human Services (NJ)
- Lee County Health Department (IA)
- Louisville Metro Public Health Department (KY)
- Mesa County Public Health (CO)
- Shelby County Health Department (TN)
- Tacoma-Pierce County Health Department (WA)

The PHIL study team includes:

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- Becca Fink, Communications Manager (report design)
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Executive Summary

Resilience Catalysts (RC) in Public Health is a national collaborative and network of local health departments (LHDs) seeking to identify structural drivers of place and race-based inequity rooted in structural racism. The RC program provides capacity-building technical assistance (TA) and facilitates collaborative learning to help participating LHDs address systemic inequities through cross-sector initiatives that foster equity and build community resilience through policy practice and program change. Using the Community Resilience (CR) framework, RC sites apply a public health approach to address the Pair of ACEs—adverse childhood experiences in the context of adverse community environments. The CR framework aligns with the goals of Public Health 3.0, encouraging collaboration across sectors to improve population health outcomes and advance equity.

The RC network is convened by the National Association of County and City Health Officials (NACCHO) in partnership with the Center for Community Resilience (CCR) at George Washington University, Centers for Disease Control and Prevention (CDC), and the American Public Health Association (APHA). Together, this group offers deep public health expertise and program administration in its delivery of capacity building TA to RC sites.

The RC evaluation identified essential elements of the RC process and TA that help LHDs operationalize Public Health 3.0 and expands understanding of RC’s preliminary impact. The evaluation used a mixed-methods design to assess both the processes and, to the extent possible, the short- and long-term outcomes of the RC program. The evaluation was led by the Population Health Innovation Lab (PHIL) at the Public Health Institute, alongside RC program administrators at NACCHO, CCR, and CDC.

The evaluation aimed to achieve the following goals:

1. Identify the essential elements of the RC process and TA, including areas of strength and opportunity that impact a RC site’s ability to operationalize the Community Health Strategist (CHS) role.
2. Assess how the RC process and TA achieves its intended outcomes of improved capacity to examine the downstream effects of structural racism, foster equity, and build community resilience, as well as, to the extent possible, other organization, community, and systems-level changes.
3. Identify how each participating community’s unique local context (e.g., demographic makeup, partners involved, community assets, political/social environment) impacts implementation of the CR framework, including the identification of scalable models and strategies/processes that are common or unique to achieve the same outcomes.
4. Assess participating LHD’s capacity for long-term sustainability of the RC effort to address the root causes of adversity and inequity after the project period ends.
5. Assess how well the RC process and TA balance local needs and the spirit of continuous improvement to facilitate scalability.

The evaluation included 12 current and former RC sites across the United States, as well as RC TA providers and funders from NACCHO, CCR, APHA, and CDC. In April and May 2023, PHIL gathered data through surveys, interviews, and document review. The PHIL evaluation team surveyed 29 RC site representatives and conducted interviews with 19 representatives from nine RC sites and 14 TA providers and funders. Key themes and insights were identified using framework analysis, constant comparison analysis, and descriptive statistics to understand RC sites’ context, participation, and progress toward intended outcomes.
The following summarizes key findings for each evaluation goal.

- **Goal 1**: Community engagement was identified as important throughout the RC process. The Pair of ACEs tree, root cause analysis, key informant interviews, group model building, logic model development, and coalition building were found to be the most essential elements of the RC process. The most essential RC TA elements include guidance on systems thinking and the personalized support offered by the RC TA team.

- **Goal 2**: The RC process and TA helped RC sites: (1) strengthen and expand community partnerships, (2) gain deeper insights on local drivers of inequities, (3) enhance capacity and skills in systems-level thinking, and (4) improve understanding of community assets and/or capacities.

- **Goal 3**: Primary local contextual factors impacting implementation of the RC process include community beliefs and norms (i.e., perceptions of stakeholders, language, stigma around sensitive issues such as mental health), community characteristics (i.e., racial diversity, urban-rural divides), political climate, and LHD infrastructure.

- **Goal 4**: RC sites and community partners reflect a strong personal commitment to addressing root causes of adversity through their community's RC initiative and express confidence that their community will continue RC efforts after RC TA concludes. To increase sustainability of RC efforts, evaluation participants highlight the need for dedicated and flexible funding to support RC staff and activities, documenting and institutionalizing the RC process within RC sites, and improving understanding of the RC process after the initial period of TA ends.

- **Goal 5**: To increase RC process scalability, it should be flexible and adaptable to RC site's needs, viewed by RC sites and community partners as an ongoing process, and incorporate more peer learning opportunities.

Lessons learned from this evaluation can be applied to help with refining the RC process, delivering TA, assessing ongoing TA for current and graduate RC sites, and supporting future cohorts. Recommendations for RC sites and RC TA providers/funders are provided at the end of this report and pertain to the following areas: 1) site readiness, 2) RC process improvement, 3) scalability of RC work, 4) sustainability of RC work, and 5) RC TA provider and funder support.

Overall, the RC evaluation presents findings from the first three RC cohorts and provides evidence-based recommendations for the RC program. Findings have implications for public health theory, local public health practice, public health training and education, and RC program funding.

- **Public health theory**: This evaluation shows that Public Health 3.0 needs a deeper integration of systems theory; LHDs may not always be the best candidate for the role of CHS; and community partners are central to the success of Public Health 3.0. Public health practice.

- **Local public health practice**: Findings demonstrate that LHDs must have a minimum level of internal and community readiness to undertake the RC process; meaningful community engagement requires that RC language and processes are accessible to all; integrating the RC process into LHD structures can facilitate implementation and sustainability; and the CHS needs clearer indicators for complex concepts.

- **Public health training and education**: Evaluation findings suggest that systems thinking is central to improving public health and building community resilience.

- **RC program funding**: Evaluation results show that dedicated funding is necessary for successful implementation of the RC process; blended and braided funding may be necessary to sustain RC work; and funding constraints can limit LHD investments in RC work.
Introduction

Background

Adverse childhood experiences (ACEs) are traumatic events during childhood and teenage years, including abuse or unstable home conditions, that can harm a child’s development and lead to health problems in adulthood.\textsuperscript{1-5} Poverty and the experience of inequity such as racism and limited community resources are reinforcing factors of ACEs, which is why the Resilience Catalysts (RC) process uses the Pair of ACEs framing to help LHDs and their partners account for the various factors contributing to ACEs as an outcome.

Adverse community environments arise from structures and systems designed to uphold place- and race-based inequities. These environments create barriers to achieving optimal social, economic, and health outcomes.\textsuperscript{2,6} Adverse childhood experiences and adverse community environments, collectively referred to as the ‘Pair of ACEs,’ work synergistically to perpetuate a cycle of trauma affecting individuals, families, and entire populations.\textsuperscript{2}

The widespread prevalence and impact of the Pair of ACEs calls for an increased understanding within the public health field regarding strategies for prevention, reduction, and elimination of community level adversity and inequity. The RC process is rooted in a community resilience approach, which supports the sustained ability for communities to prepare, withstand, and recover from acute shocks while addressing the detrimental impacts of structural racism.\textsuperscript{6}

Public Health 3.0\textsuperscript{i} offers a framework for addressing the Pair of ACEs by promoting collaboration and action across different sectors and communities to tackle root causes of health and social inequity. This includes having a Community Health Strategist (CHS) who works at a structural level and builds partnerships to address social drivers of health inequity.\textsuperscript{5,8-9} This approach also involves improving public health department accreditation, using data for decisions, and advocating for sustainable funding.\textsuperscript{7-9}

To prevent and reduce the impacts of structural racism, it is crucial to understand and address the Pair of ACEs through a community resilience approach while applying Public Health 3.0 principles. This understanding led to the creation of the Resilience Catalysts in Public Health program, which is dedicated to making communities healthier and more resilient by addressing root causes of social and health inequity.

\textsuperscript{i}Public Health 3.0 framework offers a renewed approach to public health practice by emphasizing health improvement and health equity through various strategies, including the adoption of the Community Health Strategist (CHS) role, developing cross-sector partnerships, increasing public health department accreditation, providing clear metrics and actionable data access, and exploring and advocating for flexible and sustainable funding.\textsuperscript{7-9}

\textsuperscript{i}In this report, we are using the term “social drivers of health.” Learn more about this shift in language: https://blog.nachc.org/social-drivers-vs-social-determinants-using-clear-terms/
Resilience Catalysts in Public Health Program

Resilience Catalysts (RC) in Public Health is a national collaborative and network of local health departments (LHDs) seeking to identify causes of community adversity rooted in structural racism. The RC program applies a standardized process that facilitates customized solutions for each participating LHD and their local community. RC sites utilize the Community Resilience (CR) framework as a Public Health 3.0 strategy to build cross-sector coalitions aimed at fostering equitable access to support and resources that promote community resilience. By doing so, RC sites aim to improve social, health, and economic outcomes for children and families.

The National Association of County and City Health Officials (NACCHO) convenes the RC network, offering extensive public health expertise and program administration in partnership with technical assistance (TA) providers from the Center for Community Resilience (CCR) at George Washington University, Centers for Disease Control and Prevention (CDC), and the American Public Health Association (APHA). Collectively, these partners work together to facilitate implementation of the RC process to participating RC LHD sites.

What is the RC process?

The RC process includes a series of activities that helps public health leaders build place-based coalitions committed to fostering equitable and resilient communities through policy, program, and practice change. The RC process includes the following elements:

- **Pair of ACEs Tree**: Illustrates the relationship between adversity within a family and adversity within a community.
- **Root Cause Analysis**: An analysis to identify the local systems, structures, policies, practices, and behaviors that contextualize why these things are happening?
- **Theory of Change**: A systemic approach that enables an RC site to articulate their vision for change.
- **Key Informant Interviews**: Build understanding of community context and deepen understanding around a focus issue.
- **Group Model Building**: Create a shared understanding of systems and community experiences surrounding a focus issue.
- **Causal Loop Diagrams**: Visualize the system of cause-and-effect relationships surrounding a focus issue.
- **Equity Dashboard (i.e., systems dynamic models)**: Visualize potential impacts of policy and practice changes over time.
- **Policy Briefs**: Identify key policies that will lead to the desired change.
- **Coalition Building**: Build sustainable partnerships.
- **Communications Plan**: Strategize how to communicate the RC work.
- **Logic Model**: Specify what RC sites are trying to accomplish and how they will do it.
- **Learning Sessions**: Peer learning and exchange of successes and barriers.
RC Network

As of April 2023, there were three cohorts including 13 RC sites (Figure 1).

Figure 1. RC Network Map

Progress across RC sites varies due to cohort launch timing and impact of the COVID-19 pandemic response. Table 1 summarizes progress across the RC network. As of April 2023, Cambridge Public Health Department (MA), Tacoma-Pierce County Health Department (WA), Alameda County Public Health Department (CA), and Dallas County Health and Human Services (TX) were no longer active RC sites. Two RC sites—AppHealthCare (NC) and Louisville Metro Public Health Department (KY)—have completed the RC process and are implementing the CR framework. The RC process is still in progress for the remaining sites, which include Baltimore City Health Department (MD), Cleveland Department of Public Health (OH), Florida Department of Health - Leon County, Jersey City Health and Human Services (NJ), Lee County Health Department (IA), Mesa County Public Health (CO), and Shelby County Health Department (TN).
Table 1. Participation in the RC Process by RC Site

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Launched in</th>
<th>Percent of RC Process Progress Completed</th>
<th>Pair of ACEs tree</th>
<th>Root Cause Analysis</th>
<th>Theory of Change</th>
<th>Key Informant Interviews</th>
<th>Group Model Building</th>
<th>Equity Dashboard (i.e., systems dynamic models)</th>
<th>Causal Loop Diagrams</th>
<th>Policy Briefs</th>
<th>Comms Plan</th>
<th>Logic Model</th>
<th>Learning Sessions</th>
</tr>
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<tbody>
<tr>
<td>Cohort 1</td>
<td>2019</td>
<td>AppHealthCare (NC)</td>
<td>100%</td>
<td>✔️</td>
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<td></td>
<td>Cambridge Public Health Department (MA)*</td>
<td>54%</td>
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<td>Louisville Metro Public Health Department (KY)</td>
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<td>Mesa County Public Health (CO)</td>
<td>63%</td>
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<tr>
<td>Cohort 2</td>
<td>2020</td>
<td>Alameda County Public Health Department (CA)*</td>
<td>45%</td>
<td>✔️</td>
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<td></td>
<td>Baltimore City Health Department (MD)</td>
<td>63%</td>
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<td>Florida Department of Health- Leon County</td>
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<td>Tacoma-Pierce County Health Department (WA)*</td>
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<td>✔️</td>
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<tr>
<td>Cohort 3</td>
<td>2021</td>
<td>Cleveland Department of Public Health (OH)</td>
<td>45%</td>
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<td>Lee County Health Department (IA)</td>
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<td>✔️</td>
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<td>Jersey City Health and Human Services (NJ)</td>
<td>27%</td>
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*Table 1 reflects which elements of the RC process each site participated in and/or completed based on information gathered from documents, interviews, surveys, and TA provider reports. Blank cells indicate the RC site did not begin nor complete the RC process element. The yellow columns represent outputs led by the RC TA team. Sites marked with an asterisk (*) indicate a former RC site.

Comms Plan = Communications Plan
RC Evaluation

The Population Health Innovation Lab (PHIL), a program of the Public Health Institute, designed and implemented the RC evaluation in partnership with RC program administrators from NACCHO, CCR, and CDC. The evaluation identified essential elements of the RC process and TA that help LHDs operationalize Public Health 3.0. Evaluation findings expand understanding of RC’s preliminary impact and inform implications for theory, practice, and funding in the post COVID-19 context. The RC evaluation utilized a mixed-methods design to assess both the processes and, to the extent possible, the short- and long-term outcomes of the RC program.

Evaluation Goals

The RC evaluation was informed by the RC logic model and five goals, described below. The questions that guided the evaluation for each goal are listed in Appendix A.

**Goal 1.** Identify the essential elements of the RC process and TA, as well as strengths and opportunities to improve TA to support the CHS role. This goal focused on exploring the TA, tools, and research products RC sites consider essential for advancing their capacity to foster equity and build community resilience.

**Goal 2.** Assess how the RC process and TA achieves its intended outcomes of improved capacity to examine the downstream effects of structural racism, foster equity, and build community resilience, as well as (to the extent possible) other organization, community, and systems-level changes. In addition to assessing outcomes for LHDs and their partners, this goal aimed to understand which TA, tools, and research products were used to achieve or enable each outcome.

**Goal 3.** Identify how each participating community’s unique local context (e.g., demographic makeup, partners involved, community assets, political/social environment) impacts implementation of the CR framework and/or the modification of the RC process. This goal also included identifying scalable models and strategies/processes that are common or unique to achieve the same outcomes.

**Goal 4.** Assess participating LHD’s capacity for long-term sustainability of the RC effort to address the root causes of adversity and inequity after the project period. The evaluation assessed how LHDs and their partners are continuing or preparing to continue their RC efforts. Sustainability in RC work involves maintaining or enhancing human and/or financial resources, infrastructure activities, outcomes, and relationships over time.13-14

**Goal 5.** Assess how well the RC process and TA balances local needs and the spirit of continuous improvement with a scalable process. The evaluation explored which elements of the RC process are relevant for scalability across diverse local contexts and which elements must remain flexible.
Methodology

Evaluation Design

The evaluation utilized a mixed-methods design consisting of quantitative and qualitative data collection and analysis. The evaluation used the CR framework to guide investigation into each community’s local context and key outcomes of interest.

Population and Sampling

The evaluation involved two groups: (1) 12 former and current RC LHD sites and their community partners and (2) RC TA providers and funders from NACCHO, CCR, APHA, and CDC. Despite their inactive status, the evaluation included former RC sites from Cambridge Public Health Department (MA), Tacoma-Pierce County Health Department (WA), and Alameda County Public Health Department (CA). Dallas County Health and Human Services (TX) made limited progress within the RC process due to COVID-19 response and was not included in the evaluation.

Data were collected via a survey, interviews, and document review. A referral sample of RC site representatives, including LHD staff and community partners, were invited to participate in surveys and interviews. A referral sample of RC TA providers and funders were invited to participate in interviews. A purposeful selection of RC planning and implementation documents were reviewed. Additional sampling details can be found in Appendix B.

Survey

The evaluation team distributed an online survey to current and former RC sites and community partners in April 2023. The survey sought to understand LHD and community partner perspectives on RC implementation. Thus, participation by TA providers and funders was considered inappropriate. The survey included close-ended questions regarding RC outcomes, satisfaction with and impacts of TA provided throughout the RC process, capacity to sustain RC efforts, impacts of local context on RC work, and community partners’ perspectives on the impact of the RC initiative. Additional open-ended questions allowed for further explanation of responses to closed-ended questions. On average, the survey took approximately 25 minutes to complete.

Interviews

Interviews were conducted in April and May 2023 with a referral sample of current and former RC sites, community partners, and RC TA providers and funders. Semi-structured interviews provided detailed insight into: (1) the essential elements of the RC process and TA, and (2) the manner and extent to which intended outcomes have been achieved. Interviews took about 60 to 90 minutes to complete.

Document Review

In total, the evaluation team screened 534 documents and included 181 documents in analysis to inform understanding of RC site’s local context, participation in the RC process and TA, and RC site’s progress toward intended outcomes. Documents were excluded from analysis if they did not fall within the 2019-2023 timeframe or were unrelated to any of the 12 RC sites in the evaluation population.
Data Analysis

Quantitative data were analyzed using descriptive techniques. Qualitative data were analyzed using framework analysis and constant comparison analysis. Framework analysis explored evaluation goals related to essential RC process and TA elements, outcomes achieved, local context, and capacity for sustaining RC efforts.\(^{11}\) Constant comparison analysis was used to assess how well the RC process and TA balanced local needs and the spirit of continuous improvement while maintaining scalability.\(^{12}\)

Limitations

The RC evaluation used a rigorous, mixed-methods design to increase reliability and validity of findings. However, the evaluation is not without limitations, including:

- The small survey sample prevented group-level and predictive analysis (e.g., analysis of variance, multiple regression), which limited the ability to quantify group differences and relationships among RC elements and outcomes. Due to the small sample size, framework analysis was used to provide a systematic way of assessing differences in themes across groups.

- Results from surveys and interviews may be limited by recall bias. The evaluation design mitigated this limitation by requesting multiple participants from each evaluation participant group.

- Not all RC sites and community partners participated in both interviews and surveys. One RC site (Shelby County Health Department [TN]) did not participate in the survey and three sites (Cleveland Department of Public Health [OH], Louisville Metro Public Health Department [KY], Tacoma-Pierce County Health Department [WA]) did not participate in interviews. However, because framework analysis draws on multiple data sources, all sites are represented in overall themes identified through framework analysis.

- Insufficient documentation across sites and document types (e.g., theories of change, communications plans, policy briefs) prevented the use of document measures in quantitative analysis. However, the evaluation team incorporated documents as contextual information in framework analysis.

- Evaluation findings primarily reflect LHD and TA provider/funder perspectives. The evaluation team attempted to increase community representation across RC sites with limited success, using referral sampling, targeted outreach, and requesting additional support from RC sites and TA providers.

- Given the differences in participation and progress in the RC process, outcome detection may be nascent and look different from site to site. The report highlights findings that may be impacted by timing and site-specific variations.
Results & Findings

Evaluation Participants

In total, we received 29\textsuperscript{iii} survey responses from LHD and community representatives of 11 RC sites (response rate \(\approx 48\%\)) and conducted 29 interviews with 33 LHD and community representatives representing nine RC sites and all four RC TA providers/funders (Table 2).

Table 2. Number of Interview and Survey Participants by Group\textsuperscript{‡}

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of Survey Participants</th>
<th>Number of Interview Participants</th>
<th>Number of Unique Participants From Each Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RC TA Provider / Funder</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APHA</td>
<td>N/A</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>CCR</td>
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<td>7</td>
<td>7</td>
</tr>
<tr>
<td>CDC</td>
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</tr>
<tr>
<td>NACCHO</td>
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</tr>
<tr>
<td><strong>Cohort 1 (Launched in 2019)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AppHealthCare (NC)</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Cambridge Public Health Department (MA)*</td>
<td>2</td>
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<td>4</td>
</tr>
<tr>
<td>Louisville Metro Public Health Department (KY)</td>
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<td>3</td>
</tr>
<tr>
<td>Mesa County Public Health (CO)</td>
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<td>5</td>
</tr>
<tr>
<td><strong>Cohort 2 (Launched in 2020)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alameda County Public Health Department (CA)*</td>
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</tr>
<tr>
<td>Baltimore City Health Department (MD)</td>
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<td>6</td>
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<td>Shelby County Health Department (TN)</td>
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<td>1</td>
</tr>
<tr>
<td>Tacoma-Pierce County Health Department (WA)*</td>
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<td>2</td>
</tr>
<tr>
<td><strong>Cohort 3 (Launched in 2021)</strong></td>
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<td></td>
<td></td>
</tr>
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<td>3</td>
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<td>Jersey City Health and Human Services (NJ)</td>
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<td>2</td>
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<tr>
<td>Lee County Health Department (IA)</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>29</strong></td>
<td><strong>33</strong></td>
<td><strong>52</strong></td>
</tr>
</tbody>
</table>

\textsuperscript{‡}Number of unique participants from each group was calculated by identifying how many participants from each group participated in survey only, interview only, or both interview and survey. Sites marked with an asterisk (*) indicate a former RC site.

\textsuperscript{iii}The survey collected 23 complete responses and six partial responses. Quantitative data gathered from partial responses were used in descriptive analysis. Partial responses were not included in response rate calculation.
Survey Respondent Characteristics
The majority of survey respondents (93%, n=27) represented LHDs, and a minority of survey respondents (20%, n=6) represented local government, community-based organizations (CBO), social services, or identified as a community member. Most respondents (79%, n=23) indicated having engaged in RC activities for a period of one year or longer. When asked about their individual engagement in RC activities, 83% of respondents (n=24) reported being moderately engaged or very engaged.

Interviewee Characteristics
Interviewees encompassed a wide range of positions, including health directors, community organizers, policy and program analysts, research associates, consulting specialists, and outreach coordinators. Interviewees represented:

- RC sites (9 sites; 19 individuals)
- CCR (7 individuals)
- NACCHO (4 individuals)
- CDC (2 individuals)
- APHA (1 individual)

Survey participants were allowed to select multiple responses and percentages reflect how many individuals out of all survey respondents chose this option.
Goal 1: Essential Elements

Overall findings highlight the **Pair of ACEs tree, root cause analysis, key informant interviews, group model building, coalition building**, and **logic model** as the most essential RC process elements. These elements were considered essential for setting priorities, problem-solving, fostering shared understanding, engaging the community, amplifying community voices, addressing systemic issues, and building consensus among partners. Although not explicitly part of the RC process, community engagement also emerged as an essential element of the RC process. Additionally, the most essential RC TA elements described by evaluation participants were the guidance provided to RC sites in systems thinking and the individualized support offered to RC sites by the TA provider team.

Key Findings

- Community engagement is essential throughout the RC process.
- Essential RC process elements identified by evaluation participants comprise:
  - Pair of ACEs tree
  - Root cause analysis
  - Key informant interviews
  - Group model building
  - Coalition building
  - Logic model
- Essential RC TA elements identified by evaluation participants include:
  - Individualized support provided by the RC team

Quantitative Results

On average, survey respondents rated the **logic model, key informant interviews, coalition building**, and **root cause analysis** as the most essential elements of the RC process for advancing capacity to foster equity and build community resilience (Figure 2).
Qualitative Results

Essential RC Process Elements

Evaluation participants most frequently mentioned the *Pair of ACEs tree, root cause analysis,* and *group model building* as essential RC processes for advancing capacity to foster equity and build community resilience (Table 3). RC sites and community partners value the *Pair of ACEs tree* for setting priorities, identifying community-relevant factors, and understanding the environment. In addition, evaluation participants described the *root cause analysis* as helping to identify problems, build shared understanding, meaningfully engage community, amplify community voice, and explore factors contributing to systemic racism and inequities.

“The *Pair of ACEs tree* and *root cause analysis* exercises helped us to drill down to root causes by looking at it at the systems level.”

—RC Cohort 2, LHD Representative

The *group model building* fostered shared conversations, active listening, and consensus-building among partners.
“The group model building session contributed most to building cross-sector partnerships as it was the first activity where I participated that engaged multiple sectors and members of the community who either have experience delivering services to the community or was on the receiving end of the services.”

— RC Cohort 2, LHD Representative

Although not an explicit step in the RC process, nearly all Cohort 1 and 2 sites (89%, n=8) saw community engagement as essential to successful implementation of the RC process. They emphasized the importance of including diverse perspectives so that RC efforts were representative of the entire community, not just the LHD.

“Community engagement and collaboration and building those relationships are really critical... Over these years, the money that we do get typically is for outcomes, it’s for the service [that] is something that you actually have done, right; [that] you can do. So, you gotta deliver, and they want you to deliver in a year. But in the meantime, you got to [do] outreach, you got to educate, get folks together, and you got to get prepared before you can even get to the outcome.”

— RC Cohort 1, LHD Representative
Table 3. Essential RC Process Elements by Group††

Cell color reflects strength of group reports that an element is essential to the RC process, with darker blue cells showing a higher percentage of group perceptions of an element’s essentialness. Findings should be interpreted in light of RC site process progress at the time of evaluation (shown at the top of the table). Cells marked as N/A represent instances where percentages could not be calculated because sites had not started those areas of the RC process as of April 2023.

<table>
<thead>
<tr>
<th>Average RC Process Progress Across Cohorts</th>
<th>RC Cohort 1</th>
<th>RC Cohort 2</th>
<th>RC Cohort 3</th>
<th>All RC Sites</th>
<th>RC TA Providers-Funders</th>
<th>All Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair of ACEs Tree</td>
<td>50%</td>
<td>40%</td>
<td>67%</td>
<td>50%</td>
<td>100%</td>
<td>63%</td>
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<tr>
<td>Root Cause Analysis</td>
<td>25%</td>
<td>40%</td>
<td>100%</td>
<td>50%</td>
<td>75%</td>
<td>56%</td>
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<td>100%</td>
<td>46%</td>
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<td>Logic Model</td>
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<td>N/A</td>
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<td>50%</td>
<td>46%</td>
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<td>Key Informant Interviews</td>
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<td>25%</td>
<td>38%</td>
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<tr>
<td>Coalition Building</td>
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<tr>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

††Percentage is calculated by dividing the number of cases that mentioned an element by the total number of cases in a group. Cases are individual RC sites or organizations providing TA or funding. Cases are grouped by RC site/cohort and TA provider-funder. A total of 12 RC sites and four TA provider-funder organizations were included in group analysis, with analysis across all 16 group perspectives.
**Essential RC TA Elements**

Throughout the RC process, TA providers at NACCHO, CCR, and APHA provide sites with numerous supports through capacity building activities and resources on relevant topics. RC sites identified the **individualized support** received from TA providers as being instrumental in guiding them toward successful implementation of the RC process. LHDs appreciated the one-on-one check-ins with TA providers, which were an opportunity to ask questions, collaboratively think through challenges, and stay on track with the RC process. One interviewee stated:

“The check-ins were immensely helpful… whenever there was a sticking point, something that we just couldn’t quite get past or couldn’t quite conceptualize, [the TA team] kind of stepped in and provided us some guidance there... the check-ins were a good time to get everyone in the same room and bounce ideas off each other.”

—RC Cohort 2, LHD Representative

RC sites also emphasized the importance of receiving **TA related to systems-level thinking**. TA providers helped RC sites think bigger, view processes from a systems-level perspective, and understand the interconnectedness across different sectors when developing strategies to address issues related to the Pair of ACEs, equity, structural racism, and community resilience. The TA provided on systems-level thinking better equipped RC sites to address root causes, engage with partners, and improve health outcomes. When speaking about this, an RC site participant shared gaining a systems-level orientation through:

“A deeper understanding of what has happened to a person as a child; the community influences and environment and how that impacts a child and how redlining and racism is a culprit in the deep seeded issues people have been facing for generations.”

— RC Cohort 3, LHD Representative
Goal 2: Outcomes
Overall findings highlight the most common outcomes enabled through the RC process and TA include strengthening cross-sector partnerships, increasing understanding of inequities, and developing capacity for systems-level approaches.

Data Points
78% of RC sites (n=7) from Cohorts 1 and 2 reported that the RC process and TA enhanced their partnerships and relationships while also deepening their understanding of community inequities.

Key Findings
The RC process and TA helped RC sites achieve the following four outcomes:
- Strengthen and expand partnerships and relationships.
- Increase insights into inequities.
- Build capacity and skills in systems-level approaches.
- Improve understanding of community assets and capacities.

Qualitative Results
Survey respondents were asked to select all outcomes their RC site achieved as a result of participating in and implementing the RC process. Figure 3 shows that the most common outcomes achieved were: (1) improved understanding of experiences of adversity; (2) improved understanding of community assets and/or capacities; (3) built new and/or strengthened existing cross-sector partnerships; and (4) identified community and systems-level environments. Other outcomes achieved can be found in Appendix C.
Qualitative Results

Qualitative results indicate that the RC process and TA helped RC sites achieve three outcomes: (1) strengthening and expanding partnerships and relationships, (2) understanding inequities, and (3) building capacity and skills for systems-level thinking.

Strengthening and Expanding Partnerships and Relationships

Most RC sites from Cohorts 1 and 2 (78%, n=7) reported that the RC process and TA helped them improve and expand their partnerships with key individuals, community leaders, and cross-sector partners. They found value in relationship-building, gaining new perspectives, maintaining cross-sector connections, enhancing cross-sector communication, and facilitating collaborative discussions. One participant stressed the ongoing dedication needed to strengthen partnerships throughout the RC process.

“We have quite a few folks already in this space, and the health department just has so many, many partners. Whether it’s community-based organizations, nonprofits, you name it, even private business entities. The relationships are there. It’s really just a matter of being more strategic in how we direct our efforts.”

—— RC Cohort 2, LHD Representative
Understanding Inequities
Most RC sites from Cohorts 1 and 2 (78%, n=7) emphasized that the RC process and TA increased their understanding of inequities. They gained a deeper understanding of how various factors contribute to inequities, including housing conditions, community environments, transportation disparities, food access challenges, economic instability, social drivers of health, historical segregation due to redlining, racism, and ACEs. An interviewee illustrates increasing their understanding of inequities by sharing:

“I personally was able to identify… that in all the five areas that we looked at, there was an -ism as the root cause… it was racism and the other was sexism.”
— RC Cohort 3, LHD Representative

Building Capacity and Skills for Systems-Level Approaches
More than half of RC sites from Cohorts 1 and 2 (66%, n=6) reported that the RC process and TA built their capacity and skills for thinking and analyzing at the systems-level. After participating in the RC process and TA, several RC sites described acquiring the ability to approach problems with a systems-oriented perspective.

“The entire process provided me with the ability to view the entire system, opposed to my individual siloed effort…”
—RC Cohort 2, LHD Representative

*Only one Cohort 3 site reported that the RC process and TA helped them understand inequities. This finding could be associated with Cohort 3’s early progress in the RC process (see Table 1).
*Only one Cohort 3 site reported that the RC process and TA helped them built their capacity and skills for systems-level approaches. This finding could be associated with Cohort 3’s early progress in the RC process (see Table 1).
Goal 3: Local Context

Overall findings reveal the way LHDs function, community beliefs or norms (i.e., perceptions of stakeholders, language, stigma around sensitive issues such as mental health), community characteristics (i.e., racial diversity, urban-rural divides), LHD infrastructure, and the political climate as the primary contextual factors affecting RC process implementation.

Key Findings

RC sites recognized that the most common local contextual factors affecting the implementation of the RC process include:

• Community beliefs and norms
  • This includes perceptions of stakeholders, language, and stigma around sensitive issues such as mental health.

• Community characteristics
  • This includes community characteristics such as racial diversity and urban-rural divides.

• Political context

• LHD infrastructure
  • This includes allocating staff, funding, and governance.

Data Points

59%

of RC sites (n=7) reported LHD infrastructure challenges impacting implementation of the RC process.

Quantitative Results

The survey asked respondents to specify how local contextual factors affected their RC site’s approach of the RC process. Figure 4 shows that the top two factors were the way the LHD functions and community beliefs or norms.
**Qualitative Results**

Community characteristics, political climate, and public health infrastructure emerged as the primary local contextual factors influencing the implementation of the RC process.

**Relevance of Community Characteristics**

Evaluation participants often emphasized the importance of community characteristics that influence the application of the RC process at the local level, such as racial diversity, urban-rural divides, and tensions between community members and law enforcement. Community characteristics influenced how RC sites define equity, the participation of community partners in the RC process, and community perceptions and attitudes toward collaboration. An RC TA provider/funder described how community characteristics influence the definition of equity by highlighting:

“I did some work with…a predominantly white community. What we really had to think about [when working with that community] was that equity is not always racial equity. There are other components of it such as understanding whatever the demographic realities and concerns are for that community. It is really important to make sure that we [TA providers/funders] are guiding the health departments in a way that makes sense.”

—RC TA Provider/Funder
Political Climate

The community’s political climate had varying effects on RC process implementation. Three RC sites (25%) benefited from strong political support, allowing them to focus on equity-related initiatives and engage with political leaders. Conversely, two RC sites (16%) faced limitations due to the political climate, hindering their engagement in the RC process and policy implementation. Another group of RC sites (25%, n=3) experienced both positive and negative impacts. They initially had political support for implementing the RC process, including the approval to focus on RC process efforts. However, shifts in political administrations altered the priorities and limited RC sites’ engagement with RC efforts. Several sites explained how the political administration in their state constrained their capacity to engage in discussions regarding equity and structural racism. One LHD representative, part of their LHD’s health equity team, described:

“At the time that we [the health equity team] left, there was a lot of issues around how might we use the [RC] plan, particularly with some of the issues in language such as systemic racism and talking about equity as a whole and what that means in marginalized communities. Because we had certain requirements that we had to abide by, we weren’t able to actually fulfill [the RC] plan the way I thought we would. Because there were certain restrictions to our language, we weren’t able to continue [RC] work.”

— RC Cohort 2, LHD Representative

LHD Infrastructure Challenges

More than half of RC sites (58%, n=7) reported that their LHD initially lacked the necessary infrastructure (e.g., allocated staff time, staff buy-in, funding needed for community engagement, aligned strategic plan) or faced internal challenges which impacted implementation of the RC process. All former RC sites (100%, n=3) attributed these infrastructure challenges to their LHD’s discontinuation with the RC process. One interviewee stated how these infrastructure challenges affected them by describing:

“Because we were really at the beginning stage, we didn’t actually have an infrastructure; we didn’t have allocated staff to do this work. I mean, I was allocated to lead some of this work, but I was spending, I don’t know, 10-15 hours a week. It’s just not sufficient to really lift up the work right and create momentum.”

— RC Cohort 2, LHD Representative
Goal 4: Sustainability

Findings reveal that RC sites and their community partners are committed to the RC process and confident that their community will continue RC after the initial period of TA concludes. Sustaining the RC process depends on LHD and community partner commitment, dedicated and flexible funding from diverse sources, RC process documentation, LHDs institutionalizing the RC process as an operating system across program and service areas, and better defining how to continue the RC process after the initial period of TA ends.

Key Findings

- The ability of LHDs to sustain the RC work beyond the project period relies on RC participant’s:
  - Personal commitment to continue addressing root causes of adversity through their RC initiative.
  - Confidence that their RC initiative efforts will continue after the conclusion of TA.
  - Commitment to dedicate time and resources (e.g., funding, staff time) to the effort.

- To increase sustainability of RC efforts, evaluation participants highlight the need for:
  - Dedicated and flexible funding from diverse sources.
  - Documenting the RC process for RC sites and TA providers/funders.
  - Institutionalizing the RC process as an operating system across program and service areas in LHDs.
  - Improving understanding of RC work after TA ends.

Quantitative Results

Survey respondents were prompted to assess their LHD’s capacity to sustain RC efforts after TA concludes. Figure 5 shows that communities typically plan to continue their RC initiatives, and individuals involved in the process are personally committed to the work and want to stay engaged.
Qualitative Results

Qualitative results indicate that increasing LHDs’ capacity for long-term sustainability of the RC effort requires dedicated and flexible funding, documentation of the RC process, institutionalization of the RC process within LHDs, and improved understanding of continued RC efforts after TA ends.

Dedicated and Flexible Funding

RC sites (58%, n=7) and TA providers/funders (75%, n=3) indicated the need to seek and secure dedicated and flexible funding to sustain the RC work beyond the initial TA period. Dedicated and flexible funding is necessary to compensate community members, support staff capacity, and cover initiative costs. Evaluation participants mentioned the need for funding that is not categorical or restricted, but rather flexible and supportive of sustained systems-level work.
Funding needs to be more flexible and supportive of health equity—but I think there’s a slow shift to that happening. I think having funding with requirements around health equity principles, community engagement, etc. will ensure that the work gets done regardless of changing whims of leadership, elected officials, or other external factors.

— RC Cohort 1, LHD Representative

**Documenting and Institutionalizing the RC Process**

Evaluation participants suggest the need for more documentation of the RC process, including the development of easily understood documents and clear application guidelines. This includes providing RC tools and resources in accessible and user-friendly formats that can be used independently by RC sites and their community partners. For example, self-guided materials that provide resources on the RC process, step-by-step guides that lead individuals through how to conduct specific steps in the RC process, and videos explaining RC process elements. An RC TA provider/funder alluded to the need for this by commenting:

> I think a sustainable option would be to have a self-guided set of materials that people can use to develop these capacities on their own, that allow any community—whether it’s a health department or a community member that wants to make a difference—to be able to understand the different tools available to them. And so that would mean it needs to be pretty straightforward… I’m envisioning kind of step-by-step guides, videos, etc., that provide ways for people to use the technical assistance materials without having to directly interact with us.

— RC TA Provider/Funder

Additionally, evaluation participants suggest the need to institutionalize RC concepts and process elements by building them into how the LHD operates. By incorporating RC concepts and process elements into various aspects of LHD’s operations, such as including them in strategic planning, accreditation processes, community health assessments, and community health plans, evaluation participants suggest that the RC process could become a standard and systemic way of addressing community adversity rooted in structural racism rather than a temporary one. Others described how the socialization of RC concepts and process elements across LHD departments could contribute to institutionalizing RC concepts and processes.

**Limited Knowledge about Sustaining RC Efforts Post-TA**

RC sites and community partners acknowledged a lack of understanding regarding how to continue their efforts after RC TA ends, indicating a potential gap in understanding of the long-term impact and sustainability of RC initiatives. When asked what additional supports or resources would help enable their community to sustain RC work after the TA period ends, a participant shared:

> We need to have a contingency plan in place to ensure that RC is perhaps even part of the federal community health plans, state levels, and local levels. Then, there won’t be a reason to have Resilience Catalyst be outside of the scope [of the LHD’s work].

— RC Cohort 2, LHD Representative
Goal 5: Scalability

Evaluation participants identified *coalition building* and *key informant interviews* as the most relevant and feasible elements of RC TA for scalability. They agreed that all RC TA elements were relevant and feasible in any community but stressed the importance of flexibility, adaptability, framing RC as an ongoing process, and incorporating peer learning opportunities for scalability.

Key Findings

- The most relevant and feasible RC processes identified are:
  - Coalition building
  - Key informant interviews
- To increase scalability, the RC process should be:
  - Flexible and adaptable to RC site’s needs.
  - Viewed as an ongoing process rather than a one-time project.
  - Increase peer learning opportunities.

Data Points

75% of survey respondents (n=22) agreed that the key informant interviews and coalition building were the RC processes that would be relevant and feasible to support any community, regardless of local context.

Quantitative Results

Survey respondents were asked to rate their level of agreement that RC process elements are relevant and feasible for any community, regardless of local context. Figure 6 demonstrates that *coalition building* and *key informant interviews* received the highest levels of agreement regarding their relevance and feasibility for supporting any community.
Qualitative Results

Qualitative results reveal that to increase scalability, the RC process should be flexible and adaptable to RC site's needs, viewed as an ongoing process rather than a one-time project, and increase peer learning opportunities across RC sites.

Strategies for Scaling the RC Process

Evaluation participants stressed the importance of flexibility and adaptability in the RC process, emphasizing the need for TA providers to adjust priorities and tailor the approach to each community's preferences and local context. Community's preferences and local context can influence how sites define equity, collaborate with others, and engage in the RC process.

A primary focus on properly framing the RC process as ongoing rather than a one-time project can also increase scalability. RC TA providers described that the aim is to integrate this process into the work of LHDs to continuously advance equity beyond the initial period of TA.

I have specifically heard sites refer to RC as ‘a project’ or ‘the project.’ And the project is centered around whatever issue area they choose to focus on. And so, I think that framing makes it hard to think about replicating.

— RC TA Provider/Funder

Lastly, evaluation participants suggest that increasing peer learning across RC sites could facilitate scalability of the RC work. RC sites suggested that providing LHDs and community partners with access to lessons learned and promising approaches from other sites could help scale their community's RC work.
Community Health Strategist

RC aims to operationalize Public Health 3.0 by supporting LHDs in embodying the Community Health Strategist (CHS) role. LHDs functioning as CHS play an important role in addressing the broader influences that promote health, eliminate health disparities, and advance health equity among all individuals in their community.\(^{13}\)

Although not a primary evaluation goal, the evaluation attempted to understand how RC sites defined and assumed the CHS role. Over half of survey participants from RC sites (62%, n=18) indicated familiarity with the CHS role. When asked how they define the CHS role, RC sites described CHS as leaders catalyzing change, operationalizing Public Health 3.0, and establishing connections to create a systems-level view to eliminate disparities and advance equity.

“The community health strategist is the architect behind identifying key community concerns and its root causes, believes in advancing equity through system change and strategically engaging key stakeholders in a change process to positively impact community health outcomes.”

—RC Cohort 2, LHD Representative

Evaluation participants described that the RC process helped sites mirror the key principles of the CHS. Furthermore, elements of the RC process assisted RC sites in operationalizing the role of the CHS. The **Pair of ACEs tree** helped RC sites establish priorities, identify relevant variables from a community perspective, and understand the environment to eliminate disparities and advance equity. Evaluation participants viewed **group model building** as essential for bringing partners into shared conversations and encouraging active listening and consensus-building. **Root cause analysis** helped RC sites advance capacity to foster equity and build community resilience.
Discontinued RC Sites

Three discontinued RC sites participated in the evaluation: Cambridge Public Health Department (MA) (Cohort 1), Alameda County Public Health Department (CA) (Cohort 2), and Tacoma-Pierce County Health Department (WA) (Cohort 2). Representatives of discontinued RC sites attributed their LHD’s discontinuation with the RC process to infrastructure challenges that limited their engagement, including tensions between leadership structures and red tape and bureaucracy hindering internal collaboration. Although no longer active RC sites, representatives of discontinued RC sites expressed gratitude for the TA received through the RC process and noted that it helped them advance their work in other areas.

“It was an honor to be selected to participate in the project. Our agency did not complete the project, but learned a great deal and the technical support has helped us move our current work forward.”

— Discontinued RC Site Representative

What can be learned from discontinued RC sites?

- **Resource investment and commitment** from LHD senior leadership are necessary to successfully apply and sustain the RC process. Representatives of discontinued RC sites acknowledged that achieving the desired results requires dedication and hard work from all levels of an organization or community.

- Representatives of discontinued RC sites highlighted the need to **start the RC process by assessing the LHD’s capacity for RC work**. They recommended ensuring there is adequate funding, staffing, and leadership buy-in. LHDs can use capacity assessment findings to identify where they may need additional skills or resources to succeed with the RC process.

- The **RC process needs to be integrated into the foundation of the LHD** to be sustained. During an interview, a representative of a discontinued RC site said, “it has to fit into the fabric of some existing work… it can’t be this external thing, it has to be something that kind of fits with the mission and fits with some existing initiative… that’s the way I think it can be sustained.”
Community Partner Perspectives

The evaluation captured community partner perspectives on the RC process through survey data with audience-specific questions. While only a minority of respondents (20%, n=6) identified as community partners, they reported high levels of average agreement that: (1) participating in the RC initiative was a worthwhile use of their time and resources, (2) they understood how they could contribute to achieving their community’s RC goals, and (3) they felt that what they brought to the RC initiative was appreciated and respected by others. Appendix D offers additional insight into the perspectives of community partners.

Survey participants were allowed to select multiple responses and percentages reflect how many individuals out of 29 survey respondents chose this option.

What can be learned from community partner perspectives?

- **Community partners value participating in the RC initiative.** Community partners expressed high levels of agreement that the RC initiative is worthwhile.

- **RC sites may benefit from more active community engagement.** Most evaluation participants from RC sites identified as LHD staff while a minority of participants identified as community partners. The low number of community partner perspectives in the evaluation despite targeted outreach efforts suggests the need for more community partners to be engaged in the RC initiative. RC sites can increase engagement with community partners using community engagement strategies around developing and sustaining partnerships.

- **Creating a reliable environment for the RC initiative is critical.** Community partners indicated that RC participants are not always reliable. Reliability can be built through mutual trust and respect, consistent communication, clear goals, and following through on promises.
## Recommendations

Lessons learned from this evaluation can be applied to help with refining the RC process, delivering TA, assessing ongoing TA for current and graduate RC sites, and supporting future cohorts. Recommendations pertain to: 1) site readiness, 2) RC process improvement, 3) scalability of the RC work, 4) sustainability of the RC work, and 5) RC TA provider and funder support. Table 4 organizes recommendations by category and applicable group(s).

<table>
<thead>
<tr>
<th>Site readiness</th>
<th>RC sites</th>
<th>TA Providers/Funders</th>
<th>RC Sites and TA Providers/Funders</th>
</tr>
</thead>
</table>
|                | • Ensure there is a dedicated individual to lead the process and ensure continuity in program planning and implementation  
• Clarify roles and responsibilities | • Develop a CHS curriculum to prepare individuals and organizations for the role | • Understand LHD and community readiness for RC work |
| RC process improvement | • Integrate the RC process into LHD structure, strategy, and mission  
• Integrate community members and partners throughout the entire RC process | | • Ensure RC language and processes are delivered using accessible language and through multiple channels in a comprehensive manner to all RC partners |
| Scalability of RC work | | • Maintain the adaptability of the RC process  
• Increase connections and interactions among graduated, current, and prospective RC sites  
• Develop web-based, asynchronous RC training materials | |

### Table 4: Recommendations by Category and Applicable Group(s)
Table 4. Overview of Evidence-Based Recommendations (continued)

<table>
<thead>
<tr>
<th>Sustainability of RC work</th>
<th>RC sites</th>
<th>TA Providers/Funders</th>
<th>RC Sites and TA Providers/Funders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Develop succession plans so that RC knowledge and skills are not lost</td>
<td>• Provide further training and education on topics that will improve RC site's</td>
<td>• Establish core evaluation metrics for the RC process</td>
</tr>
<tr>
<td></td>
<td>with staff turnover</td>
<td>ability to sustain RC work after TA ends</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Build LHD and partner capacity and skills to lead the RC process after initial</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TA ends</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Institutionalize RC expertise and knowledge across TA provider organizations</td>
<td></td>
</tr>
<tr>
<td>RC TA provider and funder</td>
<td></td>
<td>• Improve RC site onboarding by providing a clearer understanding of RC process,</td>
<td></td>
</tr>
<tr>
<td>support</td>
<td></td>
<td>goals, expectations, and commitment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure dedicated RC TA staffing and capacity to provide sites with adequate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>support</td>
<td></td>
</tr>
</tbody>
</table>

Site Readiness

- **RC sites should ensure there is a dedicated individual to lead the process and ensure continuity in program planning and implementation.** RC sites with dedicated staff for RC work made more progress in the RC process compared to sites that had fewer or no dedicated staff for the work. However, it is important to ensure that RC knowledge and expertise developed in one individual is documented so knowledge and momentum is not lost with staff turnover.
• **RC sites should clarify roles and responsibilities.** RC sites should articulate who is involved in the RC process, why they are involved, and each person’s responsibilities related to RC. Role clarity prepares RC sites to know who can help with various aspects of the RC process and delineate who among LHD staff and community partners is accountable for different parts of the RC work.

• **RC sites and RC TA providers/funders should understand LHD and community readiness for RC work.** Several RC sites expressed that their LHD did not fully understand the level of commitment and investment needed to implement the RC process. LHD, community, and partner readiness and capacity should be assessed from multiple angles, including but not limited to LHD leadership support for the RC process; LHD staff and community ability to prioritize RC work; existing community partnerships and levels of trust; and LHD and community readiness to address structural racism and inequities as public health issues. By assessing site readiness before starting the RC process, LHDs and TA providers/funders can proactively address areas that may prevent RC sites from effectively undertaking the RC work and provide support to ensure sites are ready to successfully apply the RC process.

• **RC TA providers/funders should develop a CHS curriculum to prepare individuals and organizations for the role.** Most RC sites expressed a lack of clarity on the CHS role. To address this, a CHS curriculum should be introduced at the start of the RC process that covers the CHS role, its relevance, active learning techniques, and practical applications. It should address key questions such as: What is the CHS role? Who is the CHS? How is the CHS role operationalized? What are the CHS competency and skill requirements?

**RC Process Improvements**

• **RC sites should integrate the RC process into their LHD structures and approaches.** The integration of the RC process into the LHD’s organizational structure, strategy, and mission will help the RC process align with LHD goals and functions. Rather than existing in one department, the RC process can be reframed as the framework through which an LHD operates.

• **RC sites should integrate community members and partners throughout the entire RC process.** It is critical that RC sites bring in perspectives from community members who are directly affected by or possess knowledge about the issues of focus. Equally important is the early inclusion of cross-sector partners in the RC process. RC sites should regularly question who is at the table and expand inclusion of community voices to increase community engagement throughout the process. This will help increase buy-in and ensure communities and partners have equitable opportunities to contribute to the RC process.

• **The RC program—including TA providers/funders and sites—should ensure RC language and processes are delivered using accessible language and through multiple channels in a comprehensive manner to all RC partners.** RC leaders and participants should refrain from using jargon and processes that may be hard for participants to understand, specifically when engaging communities. Ensure RC processes and materials are delivered in multiple languages, if helpful for community engagement. When using language that is potentially divisive (e.g., equity and/or racism), identify ways to phrase concepts to lessen political opposition and ensure language is in line with local norms.
Scalability of the RC Work

- **RC TA providers/funders should maintain the adaptability of the RC process.** Every community and LHD has a unique context that impacts their approach. Evaluation participants emphasized the need for an adaptable RC process that can cater to the specific needs of RC sites such as LHD infrastructure and workforce skills and capacities. Additionally, an LHDs’ relationship with the community, the political context in which they operate, and historical or recent crises may necessitate changes to the RC process. Changes could include adding new activities (e.g., focus groups) to help support site’s progress, shifting the order of RC activities, or adjusting how elements are implemented.

- **RC TA providers/funders should increase connections and interactions among graduated, current, and prospective RC sites.** Current and graduated RC sites can help scale the RC process by introducing prospective communities to RC concepts and processes. Furthermore, RC sites can provide training and support to one another—and to prospective RC sites—by leveraging the knowledge, expertise, and lessons learned from their own RC journey. If RC site expertise is leveraged to scale the RC work in this way, it will be important to ensure they are equitably compensated for the training and peer support they provide.

- **RC TA providers/funders should develop web-based, asynchronous RC training materials.** Materials could include tools, videos, step-by-step guides, and other resources that empower LHDs and cross-sector partners to develop CHS capacities and follow the RC process on their own. These training materials should work together with the CHS curriculum by providing guidance on the RC process, including detailed instructions for how to apply the full process and each individual element. Making RC tools and activities openly accessible for anyone who wishes to use them would be a significant step toward scaling the RC process.

Sustainability of the RC Work

- **RC sites should develop succession plans so that RC knowledge and skills are not lost with staff turnover.** To sustain the RC process beyond the initial period of TA, the RC TA team should support LHDs in developing contingency plans for leadership changes, staff turnover, and unexpected events. One option is to develop and maintain an RC manual that includes items such as key terms and definitions, RC program deliverables (logic model, theory of change, communications plan, etc.), and a partner directory.

- **RC TA providers/funders should provide further training and education on topics that will improve RC site’s ability to sustain RC work after TA ends.** Evaluation participants expressed uncertainty about how to transition from the period of RC TA to implementing their RC logic model. Training topics that could increase confidence with transitioning from RC planning to implementation include strategies for advancing policy change; funding RC work; sustaining meaningful community engagement; planning for continuity of RC processes; mapping community assets; developing shared governance structures; and communicating a compelling value proposition for the RC work.
• **RC TA providers/funders should build LHD and partner capacity and skills to lead the RC process after initial TA ends.** RC sites expressed the desire to build their capacity to continue the RC process without RC TA support. Participants requested training on how to lead elements of the process (e.g., *group model building*, developing a *theory of change*, etc.) and suggested the RC process include more of a ‘train-the-trainer’ approach so that LHDs could teach community partners and other LHDs how to apply the RC process.

• **RC TA providers/funders should institutionalize RC expertise and knowledge across TA provider organizations.** Evaluation participants frequently mentioned the importance of specific TA providers with expertise in the RC process. Staff transitions across TA provider organizations may impact the effectiveness of the RC process if a staff member with unique skills and expertise in the RC process leaves the TA provider organization. TA providers should find ways to institutionalize expertise to avoid dependence on a single person.

• **The RC program–including TA providers/funders and sites–should establish core evaluation metrics.** Measuring RC processes and outcomes using a core set of metrics will help document community actions and skills learned, evaluate progress, and establish the value of the RC process. Metrics should enable RC sites and community partners to document and monitor racial and economic disparities; structural inequities such as classism, racism, and sexism; systems change; community action; skills acquired through the RC process; and progress with cross-sector partnerships and capacity-building.

**RC TA Provider and Funder Support**

• **RC TA providers/funders should improve RC site onboarding by providing a clearer understanding of RC process, goals, expectations, and commitment.** Strategies to improve onboarding of sites include documenting the RC process more clearly, establishing clear scopes of work with deadlines, and clarifying the level of effort and necessary capacity required to engage in RC. RC TA providers should also consider developing an RC process roadmap that outlines how all RC activities fit together, the purpose of individual RC activities, and the end goal of the RC process. This will help LHDs and community partners plan for staff needs, expectations, community involvement, or other necessary inputs.

• **RC TA providers/funders should ensure they have dedicated RC staffing and capacity to provide sites with adequate support.** RC sites may need significant individualized and contextualized support, especially regarding implementation of the RC process. RC designers, implementers, funders, and TA providers should ensure they have designated staff and the capacity to adequately support sites and uphold their commitments to RC sites in a timely manner.
Conclusions

The RC evaluation presents findings from the first three RC cohorts and provides evidence-based recommendations for the RC program. Findings have implications for public health theory, local public health practice, public health training and education, and RC program funding, which are described below.

Theory

RC sites and their community partners are leveraging the RC process to operationalize Public Health 3.0, implementing strategies that advance equity and foster community resilience. The RC program demonstrates how these theories can be translated into practice, allowing researchers to empirically test strategies for effectiveness in various contexts. Evaluation findings suggest that:

- **Public Health 3.0 needs a deeper integration of systems theory and systems thinking for success.** Cross-sector collaboration and community engagement, along with a focus on social drivers of health, are at the heart of Public Health 3.0. These concepts can be best understood using a systems perspective and can better prepare LHDs to address root causes of inequities, engage partners, and improve population health outcomes. Although the current Public Health 3.0 literature emphasizes the importance of systems thinking, it does little to integrate systems theory. Further integrating knowledge about systems theory and systems thinking into Public Health 3.0 would support practitioners by connecting them with evidence-based knowledge about how to apply systems thinking strategies to their work.

- **LHDs may not always be the best candidate for the role of Community Health Strategist (CHS).** Although Public Health 3.0 theories state that “public health leaders should embrace the role of CHS for their communities,” they also acknowledge that “there are circumstances in which such leadership comes from those in other sectors.” Findings revealed some of the factors that contribute to LHDs’ inability to fulfill the role of CHS include staff turnover, varying levels of trust with community partners, local political opposition that may hinder the progress of addressing root causes of inequities, barriers to internal collaboration across departments/divisions, bureaucratic red tape interfering with RC processes, and a lack of commitment from senior leadership.

- **Community partners are central to the success of Public Health 3.0.** Public Health 3.0 theories highlight the importance of engaging community partners to generate collective impact. Evaluation findings emphasize the centrality of community engagement, suggesting this aspect of Public Health 3.0 should be further elevated by intentionally including opportunities for shared decision-making and inclusion of diverse perspectives from the community in the RC process. Two elements of the RC process that support integrating community partner perspectives are **key informant interviews** and **group model building**.

Practice

The RC program facilitates a systems-thinking approach for LHDs and their partners to address structural racism as a public health issue. LHDs can identify and develop plans for addressing root causes of adversity and inequity through knowledge, skills, and capacities gained through the RC program. As
more LHDs seek to apply the RC process, it is necessary to ensure that essential elements are accessible outside of one-on-one TA, the RC process is scalable to local context, and strategies are developed to support sustainability of the RC process and work. Evaluation findings suggest that:

- **LHDs must have a minimum level of internal and community readiness to undertake the RC process.** Findings suggest that for the RC process to be successful, LHDs must have staff with appropriate expertise in systems thinking and coalition building, dedicated funding, and senior leadership support. LHDs should be aware of their organization’s and community’s readiness and capacity to explicitly name and address systemic racism, which could be gleaned through LHD staff surveys, community conversations, community assessments, or other information-gathering approaches.

- **Meaningful community engagement requires that RC language and processes are accessible to all.** Several participants described the importance of restructuring the RC process and language to enhance accessibility and eliminate jargon, particularly when communicating with community partners.

- **Integrating the RC process into LHD structures can facilitate implementation and sustainability.** Evaluation participants discussed the importance of integrating the RC process into agency-wide structures, strategy, and mission, rather than having RC work housed in one department. Effective implementation and sustainability of the RC process requires socializing RC concepts and process elements across LHD departments and integrating RC activities into existing structures like strategic planning, workforce development, accreditation efforts, and community assessment and community health improvement processes.

- **CHS need clearer indicators for complex concepts.** Communities undertaking the RC process engage with big ideas that are tough to measure. Evaluation participants expressed the need to develop indicators for complex concepts such as community power, equity, community resilience, increased capacity to address root causes of inequities, partnership networks, and systems thinking, which would help to demonstrate positive changes resulting from the RC process.

**Public Health Training and Education**

Systems thinking is central to the RC process and intended outcomes. Training for the existing public health workforce and education for incoming professionals should prepare them with the skills to apply systems thinking in their work. Evaluation findings suggest that:

- **Systems thinking is central to improving public health and building community resilience.** Evaluation participants consistently acknowledged the interdependencies and interconnectedness of various factors that influence public health and community resilience. However, not all public health practitioners receive education or training on how to use systems thinking approaches that enable them to identify root causes or connections among related issues. To ensure all public health professionals have the tools needed to identify and understand the community as a place-based system, public health training and education must emphasize systems thinking and teach the importance of cross-sector collaboration in advancing public health and community resilience.
Funding

Implementing the RC process requires funding to support RC TA provider time to facilitate the process and LHD and community partner time to participate. Sustaining the RC process requires ongoing financial investments from diverse sources to ensure LHDs and community partners can prioritize institutionalizing the RC process community-wide by hosting or participating in trainings; convening cross-sector partners; and leading planning processes. Scaling the RC process may require additional funder investments to support RC TA providers with building an accessible learning platform for current and aspiring RC sites. Evaluation findings suggest that:

- **Dedicated funding is necessary for successful implementation of the RC process.** The RC process demands significant investments from LHDs and community partners. At minimum, funding must cover staff time to participate in the RC initiative, engage with the community, and compensate community members for their time. However, local LHDs face regular uncertainty with year-to-year funding, which too often is dependent upon the politics of elected leaders at the local, state, and federal levels. For this reason, sustaining RC initiatives may require external investments from foundations, community partners, and other stakeholders.

- **Blended and braided funding may be necessary to sustain RC work.** Evaluation participants recognized that issues addressed by RC are problems that impact every sector, and as such, community investments in RC should come from diverse sources including local government, education, social services, and philanthropy. By blending and braiding funding from diverse sources, the CHS can demonstrate community-wide commitments and increase chances of sustaining efforts to achieve shared goals.

- **Funding constraints can limit LHD investments in RC work.** Many public health funding streams have specific designations, which limit the ability of LHDs to innovate and use funds in ways that best serve their community. One promising solution is for LHDs to receive non-categorical funding that allows the needed flexibility to be responsive to local needs.
References


Appendix A. Evaluation Questions

1. What TA, tools, or research products do LHDs and their partners consider essential for advancing their capacity to foster equity and build community resilience?

2. Where can we improve elements of the RC process and TA to support LHDs in advancing their capacity to foster equity and build community resilience?

3. How and to what extent has the RC process succeeded in increasing LHD capacity to foster equity and build community resilience?
   - What knowledge, tools, skills, and strategies did LHDs gain from the RC program? Which aspects of the RC process do LHDs attribute this to?
   - How and to what extent do LHDs and their partners believe their ability to…
     - create a shared narrative of resilience in their community,
     - identify and address root causes of adversity at the structural level,
     - build cross-sector partnerships, and
     - co-create solutions with community…
     …has changed because of participating in the RC process?
   - What aspects of the RC process do they attribute to these changes in ability?

4. What outcomes have LHDs and their partners achieved to date as a result of participating in the RC process?

5. What components of RC TA, tools, or research products were used to achieve or enable each outcome?

6. How does each participating community’s unique local context influence implementation of the RC process?
   - How, if at all, did local community and political context influence decisions to modify steps in the RC process?

7. To what extent do participating LHDs have capacity to sustain the work of addressing root causes of adversity and inequity after the project period?
   - To what extent and in what ways are LHDs and their partners continuing or preparing to continue efforts to address root causes of adversity and inequity after the project period?
   - To what extent have LHDs or partners prepared or implemented changes to roles, structures, or processes to sustain the work after the program period?
   - What changes should be made to the RC program to improve LHD or partner ability to sustain the work after the program period?
   - What changes should be made to public health theory, practice, and funding strategies to support continued capacity?

8. How well does the RC process and TA balance local needs and the spirit of continuous improvement with a scalable process?
   - Which elements of the RC process are relevant and feasible for scalability across diverse local contexts?
   - Which elements of the RC process must remain flexible and fluid to ensure they support diverse local contexts?
# Appendix B. Sampling Approaches Across Data Sources

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Sampling Approach</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Documents</strong></td>
<td>Purposive sample of key planning and implementation documents for each RC site (e.g., logic models, system dynamics models, meeting notes, communications plans, and policy platforms)</td>
<td>181 documents</td>
</tr>
<tr>
<td><strong>Surveys</strong></td>
<td>Current and former RC site participants (all RC LHDs and participating community members, coalitions, CBOs, and cross-sector partners.)</td>
<td>29* survey responses from representatives of 11 RC sites (response rate ≈ 48%).</td>
</tr>
</tbody>
</table>
| **Interviews** | Referral sample of: RC LHDs (1-2 representatives per site); RC key community partners (1-2 cross-sector and/or community representatives per site); RC designers/implmenters/TA providers (1-3 representatives each from CCR, NACCHO, and APHA); RC funders (1-2 representatives) | 29 interviews with 33 individuals representing:  
- RC sites (nine sites; 19 individuals)  
- CCR (7 individuals)  
- NACCHO (4 individuals)  
- CDC (2 individuals)  
- APHA (1 individual) |

*The survey collected 23 complete responses and six partial responses. Quantitative data gathered from partial responses were used in descriptive analysis. Partial responses were not included in the response rate calculation.
Appendix C. Outcomes Achieved Through the RC Process

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Cohort One</th>
<th>Cohort Two</th>
<th>Cohort Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved understanding of experiences of adversity within our community</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Identified community and systems-level environments that shape the health of individuals in our community</td>
<td>3</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Built new and/or strengthened existing cross-sector partnerships to further equity</td>
<td>6</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Improved understanding of community assets and/or capacities</td>
<td>4</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Identified specific manifestations of inequity and/or structural racism in our community</td>
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<td>9</td>
<td></td>
</tr>
<tr>
<td>Created shared narratives about community and systems-level environments that shape the health of individuals in our community</td>
<td>7</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Built shared understanding community and systems-level environments that shape the health of individuals in our community</td>
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<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Increased capacity within my RC Core Team for meaningful change and engagement</td>
<td>3</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Increased capability for meaningful change and engagement within my RC Core Team</td>
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<td>1</td>
<td></td>
</tr>
<tr>
<td>Developed commitment to a shared vision of resilience in my community</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Applied Resilience Catalysts resources to facilitate shared understanding of experiences of adversity within our community</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Increased support from my organization to facilitate meaningful change and engagement</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Developed the ability to communicate the impact of inequity and/or structural racism in our community</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Developed a sense of hope among RC Core Team and partners for meaningful change and engagement that is possible in my community</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Fostered community power building</td>
<td>5</td>
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<td></td>
</tr>
<tr>
<td>Built consensus with community about action priorities that address social, environmental, political, or economic determinants of health</td>
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<td>1</td>
<td></td>
</tr>
<tr>
<td>Engaged partners in joint funding decisions</td>
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<td>3</td>
<td></td>
</tr>
<tr>
<td>Developed an action plan to address the root causes of social, environmental, political, or economic determinants of health</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Led initiatives with community that address root causes of social, environmental, political, or economic determinants of health</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Strengthened community and social resilience</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Implemented processes to facilitate real-time cross-sector collaboration to gather, organize, and share data</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Integrated the resources and expertise of public health to advance policy solutions</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Strengthened social cohesion and/or social capital</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Aligned department funding with the cross-sector shared vision for RC work</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developed processes to facilitate the flow of funds among cross-sector partners</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Developed a cross-sector governance structure with defined leadership and relationships that include community voice and participation</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developed an action plan to address factors contributing to inequity and/or structural racism in our community</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Cohort 3’s limited reporting on outcomes achieved through the RC process could be associated with Cohort 3’s early progress in the RC process (see Table 1).
Appendix D. Survey Respondent Ratings of Agreement on RC Initiative’s Impact from Community Perspective

- Participating in the RC initiative is a worthwhile use of mine or my organization’s time and resources. 5.2
- I feel that what I bring to the RC initiative is appreciated and respected by other participants. 5
- I understand how I can contribute (or potentially contribute) to achieving my community’s RC goals. 5
- I can describe the goals of the RC initiative in my community. 4.8
- I have gained new sources of knowledge through participation in the RC initiative. 4.75
- Most RC participants (LHD staff, partners, etc.) are trustworthy. 4.6
- Other RC participants take my opinion seriously. 4.6
- I can describe how my community’s RC goals will be achieved. 4.6
- Working within the RC Initiative helps my organization achieve its own goals. 4.5
- I have agency and shared ownership to meet the goals of the RC initiative. 4.4
- Most RC participants (LHD staff, partners, etc.) are reliable. 4.25