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# A Social Network Study To Improve Collaborative Partnerships Among the Southeastern Health Equity Council (SHEC)

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**A Social Network Study  
To Improve Collaborative Partnerships  
Among the Southeastern Health Equity Council (SHEC)**

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## **Introduction**

This report presents research conducted on the relationships among and attributes of members of the Southeastern Health Equity Council (SHEC, herein Council) to provide recommendations for partnerships, collaboration, and the recruitment of new members. The background, methods, results, and recommendations are outlined in detail throughout this report. Social networks are measured and defined as connections among people, organizations, and/or other units. SNA is a valuable and innovative tool for recognizing strengths and weaknesses in collaborative partnerships. The evaluative study presented herein can be replicated in other councils within the Regional Health Equity Councils to improve collaborations. Among the SHEC, social networking models will be designed in an effort to better understand partnerships, reach the desired goal to analyze partnerships among the SHEC, and develop a better understanding of the broad-based constituency served by the Council for the purposes of improving collaborative partnerships.

## **Objectives**

The study was conducted to analyze partnerships among the SHEC to develop a better understanding of the broad-based constituency served by the Council. The data serve the purpose of improving collaborative partnerships and engaging communities in efforts to promote health equity. The objectives of the study include: (1) to contribute to the SHEC's strategy to address health disparities in the region through the strategic analysis of partnerships and (2) to develop a report of recommendations to the SHEC on how to improve and utilize existing partnerships.

## **Southeast Health Equity Council**

Formed in 2011, the SHEC is one of ten Regional Health Equity Councils under the National Partnership for Action to End Health Disparities (NPA), which is the first national multi-sector community- and partnership-driven effort on behalf of health equity, spearheaded by the federal Office of Minority Health (OMH). SHEC corresponds to Region IV, which is comprised of eight states in the American Southeast: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. This voluntary association of 40 voting members (5 per state) brings together leaders from diverse backgrounds in minority health and health disparity elimination. This includes healthcare providers, healthcare-focused organizations, academia, public health agencies, economic development, faith-based organizations, grassroots organizations, and other non-profit organizations and businesses. The councils reinforce the need for multi-sector linkages as a key strategy for ending health disparities in America. The diversity of the SHEC ensures adequate input from diverse sectors on the council's efforts to understand and address health disparities in the region.

## Background on SNA in Health Collaborations

Many health organizations have begun to pursue collaborative approaches for addressing community-level health issues. Collaboration has gained renewed attention of public health scholars (Bingham & O'Leary 2006), as this has become an increasingly popular approach for addressing community health in a cultural and contextual way. Therefore, the importance of collaboration on health focuses on serving the collective interests of the participating organizations. The people involved in and employed in the collaboration of health interchangeably encourage the partnership or successful projects or both in order to promote common goals.

Health related partnerships can be defined as a local coalition of independent public health, health care, and social care providers that focus on improving community health within the context of limited resources and coordinating an integrated provision of care (Plochg, 2012). Coalitions have become a popular mechanism of implementing strategies to deliver preventive methods and are currently a popular tool for promoting community-based solutions to health disparities (Roussos, 2000). Private foundations, granting agencies, and other public health organizations assume that participation of community members in health promotion coalitions will increase the likelihood of program success.

Key characteristics of coalitions are related to effectiveness as measured by member satisfaction, commitment to the coalition, and the quality of planning efforts (Butterfoss, 2016). Council effectiveness and factors contributing to effectiveness have typically relied on case studies. While case studies provide descriptive information about the functioning and quality of councils, studies of multiple settings are central to understanding what factors explain variability in perceived effectiveness across councils. Further, the relatively few studies that have examined multiple settings often ignore the multi-level nature of studying councils by failing to disaggregate individual and council level effects (2005). In conclusion, there is no single best way to implement a partnership that improves population health, nor is there one true way of evaluating its success (Plochg, 2012).

Acknowledging that health equity and health disparities efforts are increasingly reliant on coalitions means that we must have resources over the next decade to design, test, and implement interventions in these areas through partnership studies (Berkman, 1995). Social network analysis (SNA) can be used as a tool to examine coalition building and partnerships that are crucial to health equity (Luque, 2011; Bright 2016; Honeycutt & Strong, 2011). It is known that network analysis has been an invaluable tool in supporting the study of coalitions and that SNA has helped to provide researchers with an understanding of the complex relationships that exist between organizations. However, coalitions can also have detrimental effects if they are not properly formed and managed. Potential damage to relationships may hinder future initiatives. More efforts must be made to break through coalition barriers to help facilitate diffusion of information and innovation, and build productive relationships (Chu, 2015). In addition, it is a positive sign for future partnerships development and expansion when coalition partners rate each other highly on trust (McQuillough, 2016). Such factors can be measured using SNA.

## Methods

We used social network analysis (SNA) to assess the existing relationships among members of the SHEC and to identify opportunities for improving these relationships to advance the effectiveness of the SHEC in meeting its stated objectives. This section outlines the methods of survey development, response recruitment, and data analysis.

### Survey Development

A survey instrument was adapted from that used by the University of Colorado PARTNER Tool and the Gulf States Health Policy Center (GS-HPC). The survey instrument is provided in Appendix A.

### Recruitment

Out of 40 council members, 32 (80%) council members responded to the member survey. Through the process of reaching out to members via email and calls, compliance was difficult to obtain in a timely matter. This prolonged the study findings, which shows greater improvement is needed for not only the study's desired goals, but also shows how there are non-active members in SHEC through this task alone.

### Data Analysis

The data were analyzed by first looking at descriptive statistics of the pre-SNA questions. Next, we assessed the relationships between SHEC members, as a whole council, by committee, and by state. Finally, we assessed the partnerships contributed to the SHEC by member affiliations. These results are presented in the next section and discussed in the conclusions section to draw recommendations for the SHEC. To analyze the networks, we used UCInet software for social network analysis.

## Results

This section presents the results of the SHEC social network survey in the areas of descriptive statistics, membership analysis, and social networks.

### Descriptive Statistics

The SHEC is comprised of representatives from many different areas, with Academic-Public Health, Non-Profit Public Health, and State Employees from Public Health identified as the classification for most positions (see Figure 1). The respondents were asked to identify the SHEC committees with which they are affiliated. We note that no respondents selected "Awareness," because as of December 2016, this committee no longer exists (see Figure 2).

In the following two figures, we note that SHEC members are optimistic about the direction of the SHEC. Specifically, to date, no SHEC members agreed that SHEC has exceeded their expectations; however, in the next year, 12% of members expect that SHEC will exceed their expectations (see Figure 3).

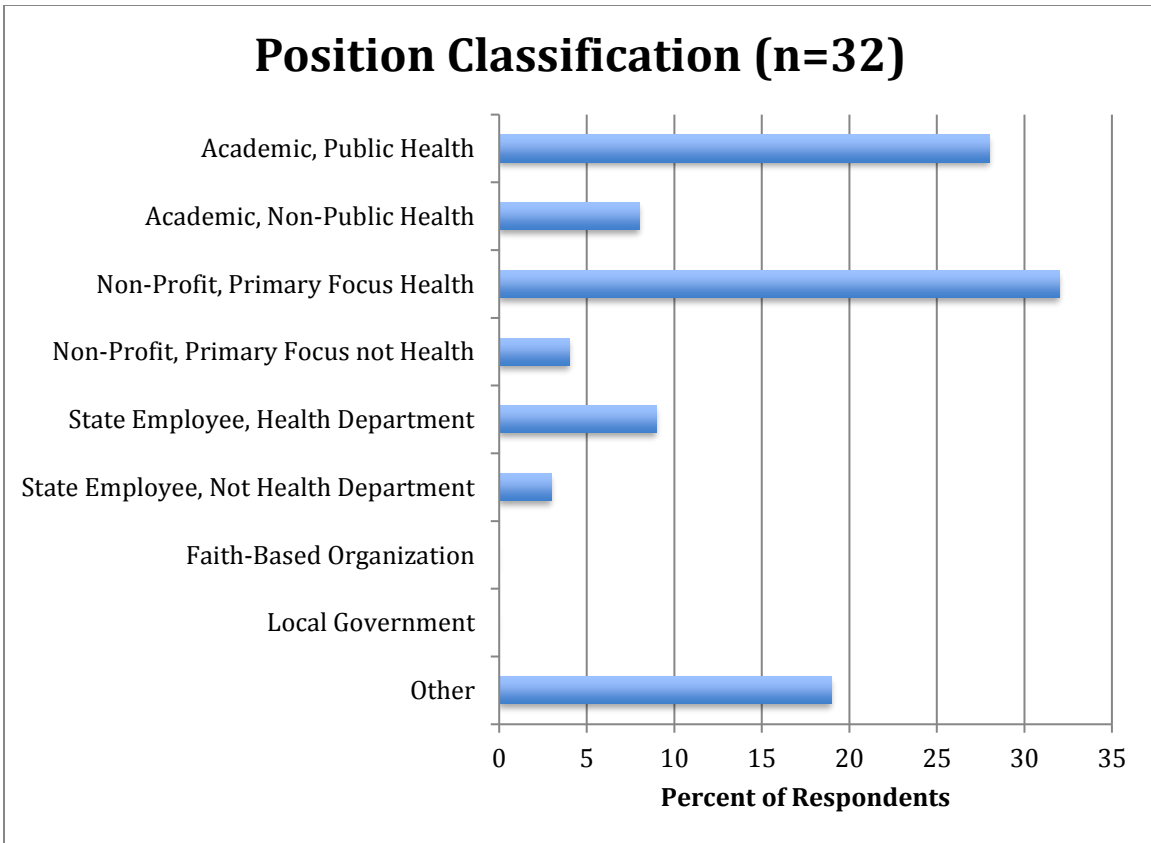


Figure 1: Member Position Classifications

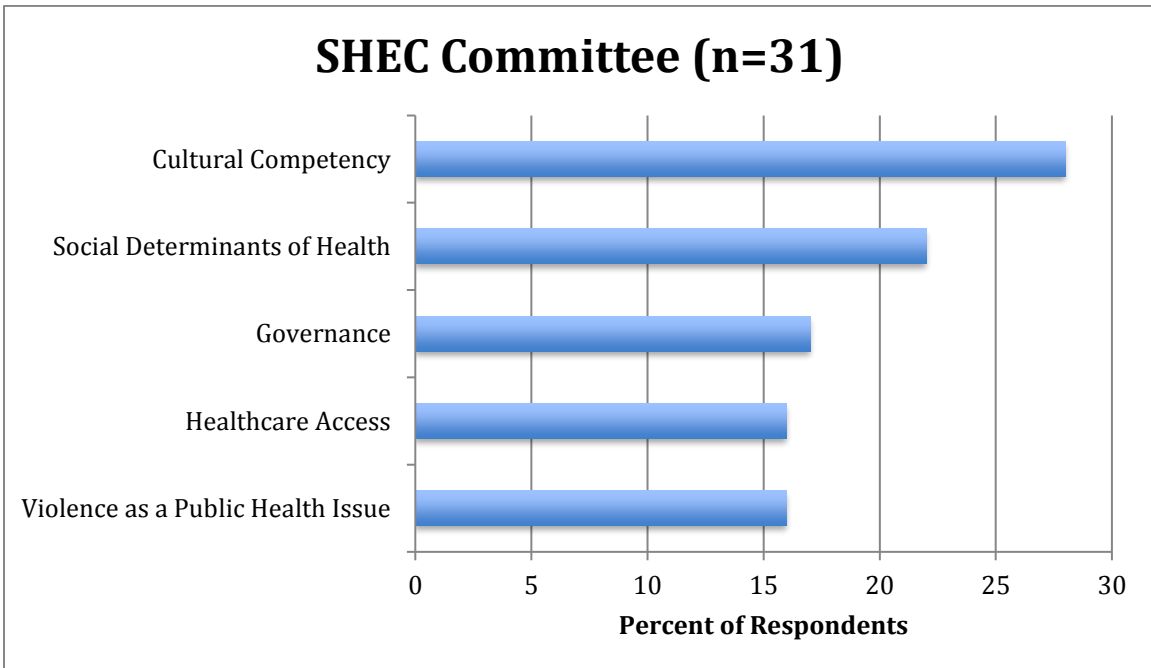


Figure 2: Member SHEC Committee

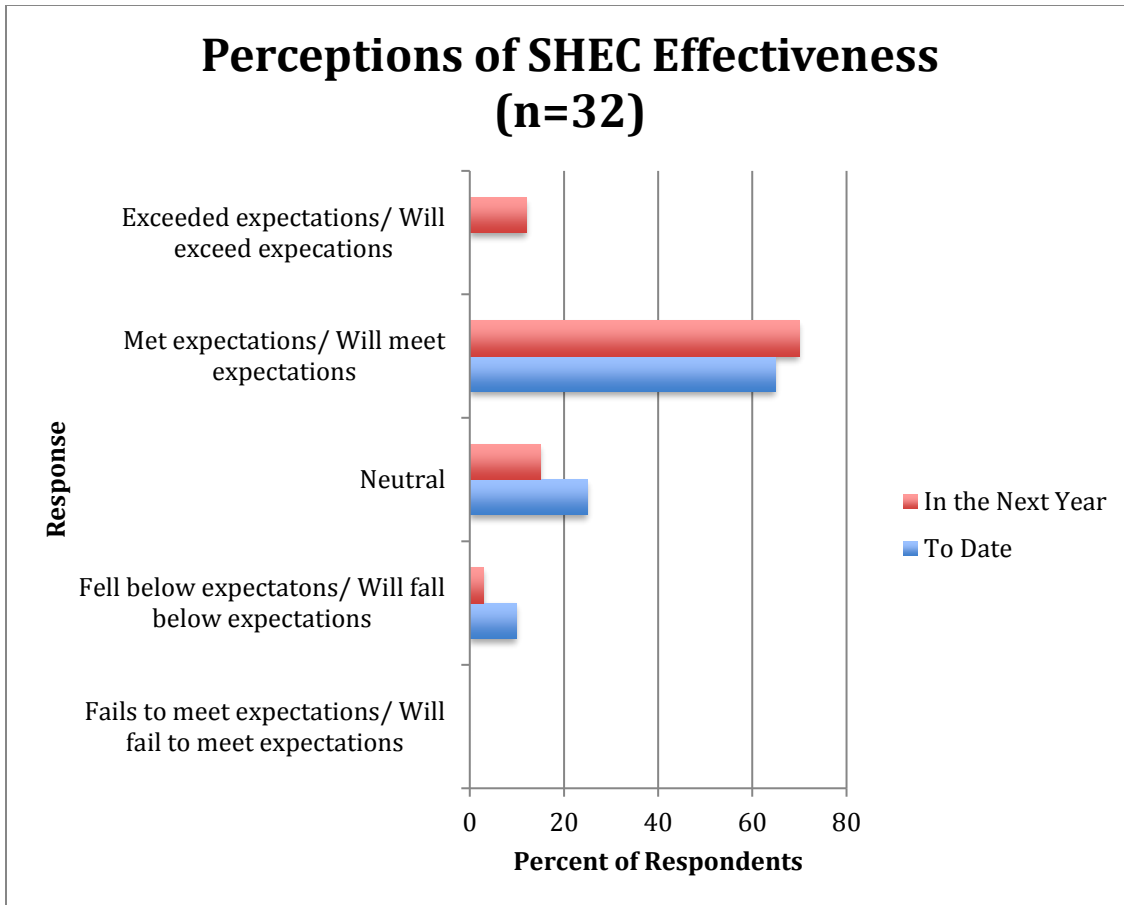


Figure 3: Perceptions of SHEC Effectiveness in Meeting Objectives

### Membership Analysis

Respondents were asked to indicate what populations they worked with in regards to health. The responses were coded according to health area demographics, including race, age, income, and gender. The connections between members within these health areas were quantified by total number of connections, total number of 5's (personally worked with) reported, and the lowest number of connections by a single member within each health area (Table 1).

### Summary of Attributes Tab

Twenty members (50%) were affiliated with health areas involving race, 14 (35%) with health areas involving age, 12 (30%) with health areas involving income, and eight (20%) with health areas involving gender. Four (10%) respondents were affiliated with health areas involving all four attributes, and an additional five (12.5%) with areas involving three of the four attributes.

With 22 SHEC members affiliated with race related health areas, there were 462 responses measuring connections that could exist between members. Of the 462 possibilities, 387 (83.8%) responses indicated an existing relationship. Of these 387



responses, just 38 (9.8%) indicated that they had personally worked together. Each respondent in the health area had at least 11 (55%) connections to others in the area.

Of the 14 SHEC members affiliated with age related health areas, there were 182 responses measuring connections that could exist between members. Of these 182 possibilities, 132 (72.5%) responses indicated an existing relationship. Of these 132 responses, 22 (16.6%) indicated that they had personally worked together. Each respondent in the health area had at least four (28.6%) connections to others in the area.

Of the 12 SHEC members affiliated with income related health areas, there were 132 responses measuring connections that could exist between members. Of these 132 possibilities, 91 (68.9%) responses indicated that a relationship existed. Of these 91 responses, only 15 (16.5%) indicated that they had personally worked together. Each respondent in the health area had at least four (33.3%) connections to others in the area.

Of the eight SHEC members affiliated with gender related health areas, there were 56 responses measuring connections that could exist between members. Of the 56 possibilities, 32 (57.1%) responses indicated an existing relationship. Of these 32 responses, just 4 (12.5%) indicated that they had personally worked together. Each respondent in the health area had at least three (37.5%) connections to others in the area.

The respondents reported their primary and secondary organizations, as well as other affiliations. These responses were categorized based on the SHEC membership overview sectors (See Table 2). Education and research was the most common sector among primary organizations. However, civic, non-profit, & community-based organizations were most common among secondary organizations, and all affiliations. There were no reported media/communication organizations among any of the organizations or affiliations.

**Table 1: Attribute Connections**

<i>Health Area</i>	N	Existing Relationships (%)	“Personally Worked Together” (%)	Minimum Connections (%)
Race	20	83.8%	9.8%	55.0%
Age	14	72.5%	16.6%	28.6%
Income	12	68.9%	16.5%	33.3%
Gender	8	57.1%	12.5%	37.5%

**Table 2: Affiliations by Sector**

	Primary Organization	Secondary Organization	First Affiliation	Second Affiliation	Third + Affiliations
Education and Research	16	5	6	3	9
Health & Human Services	5	4	4	1	7
Government	3	3	1	0	7
Health Professionals	2	2	0	0	0
Populations & Communities	2	2	3	1	4
Private	2	2	1	4	0
Civic, Non-Profit, & Community-Based	1	13	15	16	58
Media/ Communications	0	0	0	0	0

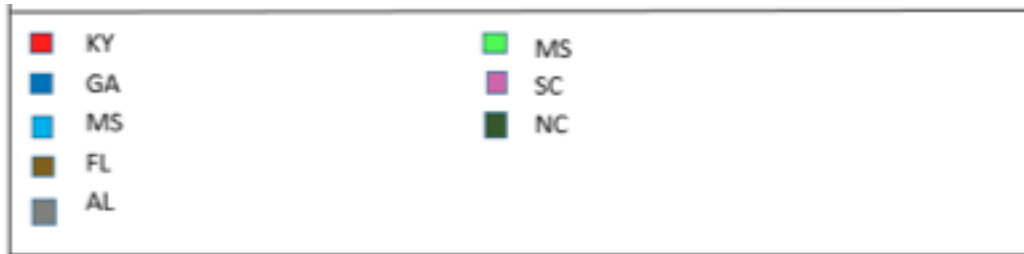
### Social Network Analysis

Next, we analyzed the relationships among members of SHEC to assess effectiveness in partnerships and opportunities for improving collaboration. SHEC members rated their relationship (on a scale from 1 to 5, see key below) with all other members of SHEC. In the social network maps presented in this section, each square is a SHEC member and each line between squares represents the existence of a relationship. The size of the square is representative of the member's power in the SHEC network. Power is calculated as a weighted measure of a member's number of connections, as well as the level (1-5) of those connections.

#### RELATIONSHIP KEY:

- 1= Do not know
- 2= Know only by name, wouldn't know by face
- 3= Casually know as a member of SHEC
- 4= Have worked together as part of a group
- 5= Have worked together personally

STATE KEY:



We first looked at the distribution of relationships among the SHEC by identifying relationships as 1, 2, 3, 4, or 5 (see key above). Each respondent answered questions about their relationship with all other SHEC members (see Appendix A for the survey instrument) for a total of 1,214 relationship data points to analyze. Among these, the frequency distribution was as follows:

- 313 responses indicate a level one relationship (25.8%)
- 145 responses indicate a level two relationship (11.9%)
- 376 responses indicate a level three relationship (31.0%)
- 235 responses indicate a level four relationship (19.4%)
- 115 responses indicate a level five relationship (9.5%)
- The mean relationship was a 2.67

In the figure below, we map the relationships present at each of these five levels to visualize the prevalence of each level of partnership. Aligning with the data frequencies above, the majority of relationships (68.7%) are occurring less than a four or a five, which indicates ample opportunities for improving collaborative activities among SHEC members. In fact, less than 10% of relationships among SHEC members are at the highest level of collaboration.

Next, we assessed relationships by committee. We conclude that there are differences in the composition of the networks between committees that indicate room for improvement. However, we also note that some committees were just formed in December 2016, which would impact their current levels of collaboration. The social networks below represent relationships at a level three or greater. However, even when accounting for casual relationships (as well as partnerships), each committee has at least one SHEC member who is not connected to other members. Finally, we note that the power positions (represented by larger squares) are distributed across the committees and that the states (represented by colors) are well distributed across the committees.

Third, we looked at the relationships among members by state using all relationships at a level three or above. There is a wide range of relationships from 100% of all Tennessee SHEC members having a relationship to no Florida SHEC members having a relationship. We also note through visualizing the state networks that the power positions within SHEC are not equally distributed across the states that comprise the SHEC.

Finally, we assessed affiliations among the SHEC members. As council members are representing larger communities, it is important to know both the organizations they are bringing information in from and the organizations from which they are taking information back, as it related to the mission of SHEC. The correlation between number of affiliations (number of organizations that the Council member is a part of outside of

SHEC) and his/her power in the SHEC network (their degree centrality) is 0.225. For affiliations, SHEC members have between 2 and 14 organizational affiliations (mean= 6.4) for a total of 199 organizations represented among the SHEC members. A full list of these affiliations has been redacted from the report for confidentiality.

Figure 4: Network Maps by Level of Relationship

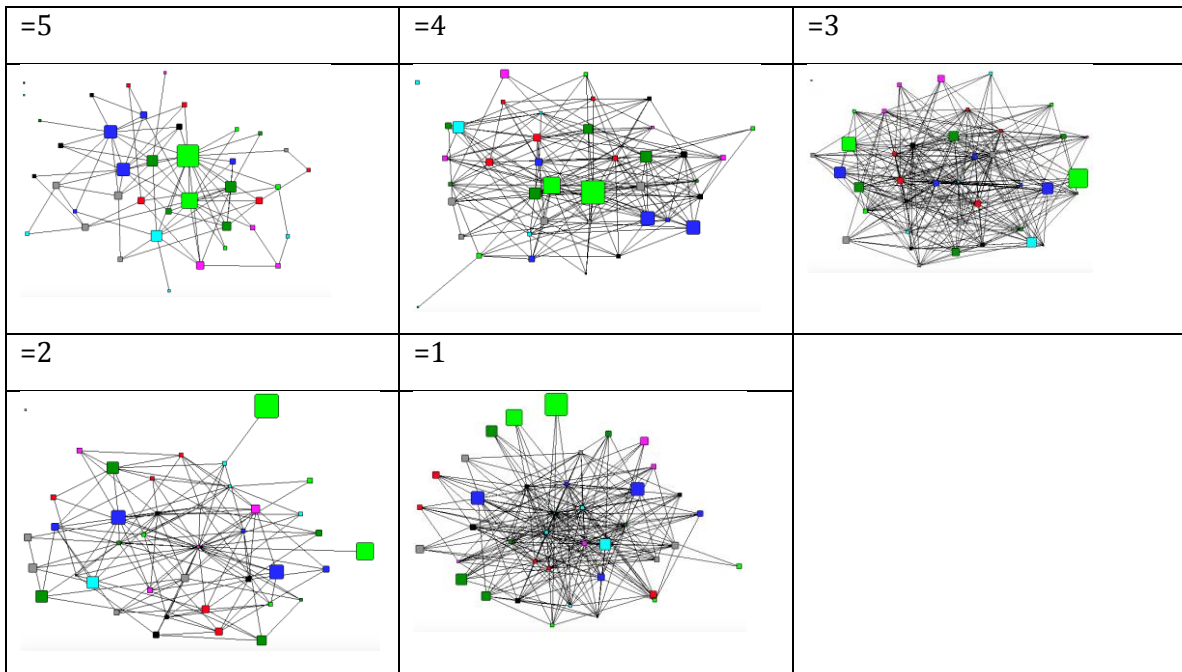
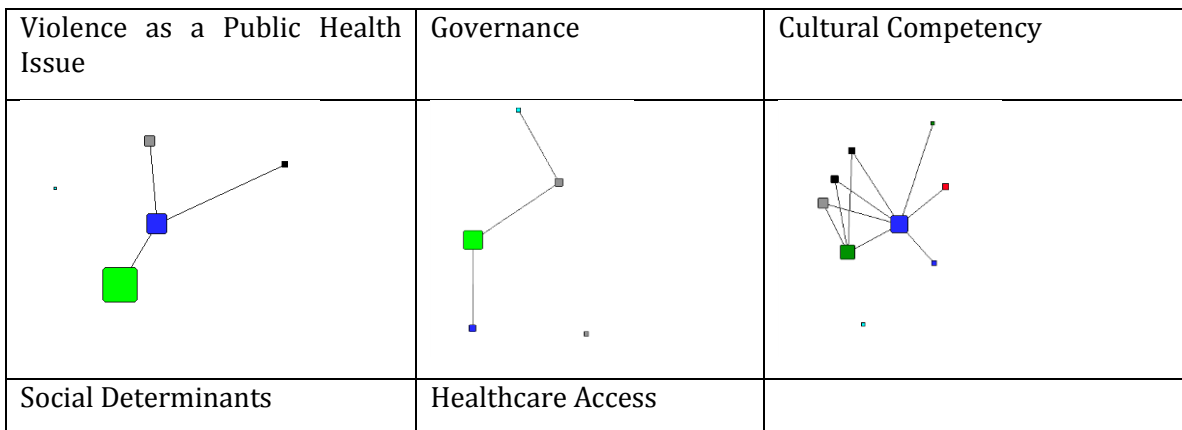


Figure 5: Network Maps by SHEC Committee



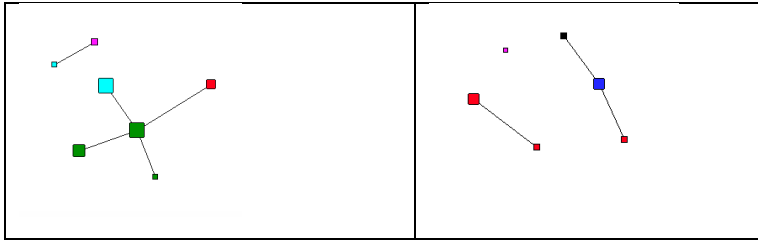


Figure 6: Network Maps by State Representation

Mississippi	Tennessee	North Carolina	South Carolina
Alabama	Florida	Georgia	Kentucky

## Conclusion

The analysis reveals many strengths and weaknesses seen within the SHEC. The strengths consisted of how there was a powerful head member among majority of committees, showing leadership and relationship impact. As a whole, many members know each other by face and are working together for goal purposes. However, we note below many opportunities for improving these relationships and for strengthening the SHEC.

In contrast, it was noted that one state in particular was not working together at all, with the opportunity for to bridge ten absent relationships. The lack of relationships does not benefit the council's goal as a whole to improve health equity. Some members also lack many relationships among their committees. This not only puts a limit on improving health equity but eliminating health disparities in this region alone.

This report concludes with recommendations to the SHEC in two areas: (1) collaboration and partnerships and (2) filling strategic gaps within the Council. Finally, we provide recommendations for future research in these areas.

## Collaboration and Partnerships

- There is a significant gap in the number of, and strength of, relationships between incoming and returning members (those in their second year or more) of the SHEC. Based on this observation, we recommend an onboarding mentorship program in which returning members are paired with new members to provide guidance in efforts related to the mission of the SHEC. Mentors can be identified based on common state association, common health area, or common committee within SHEC.
- The committee social networks reveal that (1) not all members of each committee are working as part of that committee and (2) there are distinct differences in the level of collaboration between committees. Based on this observation, we recommend that (a) each committee work to include all members of their committee in current projects and programs and (b) the success of the committees with higher degrees of collaboration be documented and replicated in the committees with lower levels of collaboration.
- We find state collaboration is much more limited than committee collaboration. With the exception of Tennessee, Council members do not know all other members in their state. Based on this observation, we have two recommendations (a) leadership positions within the SHEC be sensitive to states represented to ensure that actor power is distributed among the states, (b) states coordinate efforts to communicate about health issues, events, and programs relevant to their individual states, and (c) a state leadership designation be made for an individual within each state responsible for coordinating that state's Council members.

## Strategic Gaps in Partnerships

- No Council members represent faith-based organizations or local government. Given the role that these stakeholders play in health in the Southeast, we recommend representation from these communities on the SHEC or as advisors to the SHEC.
- We find that there are 200 organizations represented on the SHEC (inclusive of the SHEC), which presents a strength of the Council in terms of constituency and dissemination. However, this strength is not fully achieved when Council members are not active within the SHEC. Based on this observation, we recommend that a Partnership Directory is utilized to identify the affiliations of SHEC members and to utilize these partnerships strategically for both input (expert knowledge of specific health areas and regions) and output (dissemination/ communication of efforts of the SHEC).
- According to the data, the connections among SHEC members within health area demographic groups was relatively strong. However, the amount of members who had reported working personally with these connections was low. Therefore, we recommend an intervention that targets this deficiency. A member within each area should be identified who has a high number of connections. He or she would

be responsible for identifying areas of collaboration between specific members. This would increase the amount of relationships in the network that could report working personally with each other.

- Within the organizations and affiliations data, the lack of media/communications respondents shows a need for expertise in this area. We recommend a search be conducted to identify personnel in this sector who could fill this gap and contribute to SHEC.

### Future Research

- We recommend that this study be reproduced annually following the implementation of the aforementioned recommendations to assess progress in SHEC social networks. The data provided herein can serve as a baseline evaluation for charting growth in the areas of collaborations and partnerships and in strategic gaps in partnerships.
- We recommend that this study be replicated in other RHEC regions to allow for each of the regions to identify their own strengths and weaknesses in collaborations, partnerships, and representation. This will also allow the RHEC to identify regions, committees, and states that exhibit exemplary collaboration and for these to be studied and replicated. Finally, these data can be used to assess the relationship between strong collaboration and effectiveness in work towards eliminating health disparities in the United States.



**Mid-Atlantic Regional Health Equity Council (RHEC III)  
Spring 2017 Internship Description**

**Preceptors:** Dr. Candace Forbes Bright (SHEC Member, Mississippi), The University of Mississippi  
**Intern:** Hannah Scott, Jackson State University

**Goal**

The following survey is being administered to analyze partnerships among the Southeastern Health Equity Council (SHEC) to develop a better understanding of the broad-based constituency served by the Council for the purposes of improving collaborative partnerships and engaging communities in efforts to promote health equity. The results will contribute to the SHEC's strategy to address health disparities in the region through the strategic analysis of partnerships. SHEC members will receive a report of recommendations on how to improve and utilize existing partnerships based on the responses to this survey.



## SHEC Partnerships Survey

### 1. Please provide the following information:

Name:

State represented:

Official title in current position:

City/community represented:

Primary organization represented:

Secondary organization represented:

What year did you join SHEC?

### 2. How would you classify your position?

- Academic- Public Health
- Academic- Non-Public Health
- Non-Profit, Primary focus health
- Non-Profit, Primary focus other than health
- State employee, health department
- State employee, not in health department
- Faith-based organization
- Local government
- Other (please specify):

3. SHEC Committee (please check one)

- Cultural Competency
- Social Determinants of Health
- Governance
- Awareness
- Healthcare Access Committee
- Violence as a Public Health Issue

4. Please list all organizations (beyond those mentioned in question one) for which you currently have an association or membership. Please list the organization names by level of involvement, starting with the organization in which you are most involved.

1:

2:

3:

4:

5:

6:

7:

8:

9:

10:

11:

12:

5. Please complete the following regarding the work you do in health equity.

Population you serve  
(Specific race/ethnicity?  
Gender? Economic class?  
Age? Etc.):

Top health focus  
(Examples:  
Infant/maternal health,  
healthcare access, etc):

Secondary health focus:

6. To date, how effective do you think the SHEC has been in meeting its stated objectives?

- Failed to meet expectations
- Fell below expectations
- Neutral
- Met expectations
- Exceeded expectations

7. In the next year, how effective do you think the SHEC will be in meeting its stated objectives?

- Will fail to meet expectations
- Will fall below expectations
- Neutral
- Will meet expectations
- Will exceed expectations

## SHEC Partnerships Survey

8. Of the list of SHEC members, please indicate your level of relationship from 1 (do not know) to 5 (have worked together personally). Note: responses increase in level of relationship.

	This is me.	1 (do not know)	2 (know only by name, wouldn't know face)	3 (casually know as a member of SHEC)	4 (have worked together as part of a group)	5 (have worked together personally)
Bettina Byrd-Giles (AL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keecha Harris (AL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
David Dagostino (AL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sunny Slaughter (AL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thometta Cozart (AL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patria Algula (FL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alicia Best (FL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chanda Holsey (FL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diana Lee (FL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Islara Souto (FL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alred Yin (GA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Harry Helman (GA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Victoria Huynh (GA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delmonte Jefferson (GA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brian McGregor (GA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lacey McNary (KY)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vivian Lasley-Bibbs (KY)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Michelle Reece (KY)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ada Carlile (KY)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medina Tipton (KY)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mina Li (MS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Candace Forbes Bright (MS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Leslie Hossfeld (MS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jin Zhang (MS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	This is me.	1 (do not know)	2 (know only by name, wouldn't know face)	3 (casually know as a member of SHEC)	4 (have worked together as part of a group)	5 (have worked together personally)
Gladys D. Lundy (NC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bronwyn Lucas (NC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cornell Wright (NC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shepeara Hall (NC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rumana Rabbani (NC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Brenda Hughes (SC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lynette Gibson (SC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Melinda Gillespie (SC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pamela C. Hull (TN)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cherry L. Houston (TN)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kenneth S. Robinson (TN)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consuelo Wilkins (TN)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Marino Bruce (TN)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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## Appendix C: Executive Summary

### Collaboration and Partnerships

- There is a significant gap in the number of and strength of relationships between incoming and returning members (those in their second year or more) of the SHEC. Based on this observation, we recommend an onboarding mentorship program in which returning members are paired with new members to provide guidance in efforts related to the mission of the SHEC. Mentors can be identified based on common state association, common health area, or common committee within SHEC.
- The committee social networks reveal that (1) not all members of each committee are working as part of that committee and (2) there are distinct differences in the level of collaboration between committees. Based on this observation, we recommend that (a) each committee work to include all members of their committee in current projects and programs and (b) the success of the committees with higher degrees of collaboration be documented and replicated in the committees with lower levels of collaboration.
- We find state collaboration is much more limited than committee collaboration. With the exception of Tennessee, Council members do not know all other members in their state. Based on this observation, we have two recommendations (a) leadership positions within the SHEC be sensitive to states represented to ensure that actor power is distributed among the states, (b) states coordinate efforts to communicate about health issues, events, and programs relevant to their individual states, and (c) a state leadership designation be made for an individual within each state responsible for coordinating that state's Council members.

### Strategic Gaps in Partnerships

- No Council members represent faith-based organizations or local government. Given the role that these stakeholders play in health in the Southeast, we recommend representation from these communities on the SHEC or as advisors to the SHEC.
- We find that there are 200 organizations represented on the SHEC (inclusive of the SHEC), which presents a strength of the Council in terms of constituency and dissemination. However, this strength is not fully achieved when Council members are not active within the SHEC. Based on this observation, we recommend that a Partnership Directory is utilized to identify the affiliations of SHEC members and to utilize these partnerships strategically for both input (expert knowledge of specific health areas and regions) and output (dissemination/ communication of efforts of the SHEC).
- According to the data, the connections among SHEC members within health area demographic groups was relatively strong. However, the amount of members who had reported working personally with these connections was low. Therefore, we recommend an intervention that targets this deficiency. A member within each area should be identified who has a high number of connections. He or she would be responsible for identifying areas of collaboration between specific members. This would increase the amount of relationships in the network that could report working personally with each other.
- Within the organizations and affiliations data, the lack of media/communications respondents shows a need for expertise in this area. We recommend a search be conducted to identify personnel in this sector who could fill this gap and contribute to SHEC.

### Future Research

- We recommend that this study be reproduced annually following the implementation of the aforementioned recommendations to assess progress in SHEC social networks. The data provided herein can serve as a baseline evaluation for charting growth in the areas of collaborations and partnerships and in strategic gaps in partnerships.
- We recommend that this study be replicated in other RHEC regions to allow for each of the regions to identify their own strengths and weaknesses in collaborations, partnerships, and representation. This will also allow the RHEC to identify regions, committees, and states that exhibit exemplary collaboration and for these to be studied and replicated. Finally, these data can be used to assess the relationship between strong collaboration and effectiveness in work towards eliminating health disparities in the United States.