Community Partnerships

Theresa Green, PhD, MBA

Director, Community Health Policy and Education, Center for Community Health and Prevention, University of Rochester Medical Center

Agenda

- **Introductions**
  - HANYS AHEI team
  - AHEI faculty
- **Our partners**
- **Session 8:**
  - Community Partnerships
- **Upcoming session**

HANYS AHEI team

Kathleen Rauch, RN, MSHQS, BSN, CPHQ

Vice President, Quality Advocacy, Research and Innovation and Post-acute and Continuing Care

Christina Miller-Foster, MPA

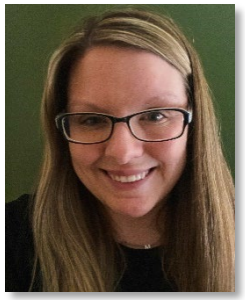
Senior Director, Quality Advocacy, Research and Innovation

Morgan Black, MPA

Director,
AHEI

Maria Baum, MS, RN, CPHQ

Project Manager,
Mohawk Valley



Rachael Brust, MBA

Project Manager,
North Country

Kira Cramer, MBA

Project Manager,
Downstate

HANYS faculty

Julia E. Iyasere, MD, MBA

Executive Director, *Dalio Center for Health Justice, NewYork-Presbyterian*
Senior Vice President, *Health Justice and Equity, NewYork-Presbyterian*
Assistant Professor, *Medicine, Columbia University Irving Medical Center*

Theresa Green, PhD, MBA

Director, *Community Health Policy and Education, Center for Community Health and Prevention, University of Rochester Medical Center*

Our funder and partner

Mother Cabrini HEALTH FOUNDATION

DataGen® Insights for Healthcare®

Our funder

Funding from the Mother Cabrini Health Foundation allows HANYS to expand its capacity to provide education, direct support, tools and data to our members in a strategic way. With this learning collaborative, we strive to effect lasting change in health equity at the local level by engaging providers and community stakeholders to address health disparities.

Our partner

DataGen develops custom analytics for participants to help them understand how and where communities are affected by health disparities so they can develop tailored interventions.

Presenter

Theresa Green, PhD, MBA

Director, Community Health Policy and Education, Center for Community Health and Prevention, University of Rochester Medical Center

Community Partnership

HANYS AHEI Presentation

Theresa Green, PhD, MBA

May 21, 2024

Key takeaways

1. Community engagement is critical for health equity and for the long-term success of any intervention
2. There are many ways to partner with the community. Find the ways that work for you and commit to advancing your efforts
3. Community engagement should be intentional, meaning there should be a plan, a new process for intervention, and an evaluation or reflection of the partnership

1.

Community engagement is critical for health equity and for the long-term success of any intervention

Mission Statements

…**improve the well-being of patients and communities** by delivering the highest quality healthcare in a safe, compassionate environment enriched by education, science and technology.

…**improving the health of our community** and is dedicated to providing compassionate, comprehensive and inn ative health care in a safe envi tient always comes first.

Health = a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity

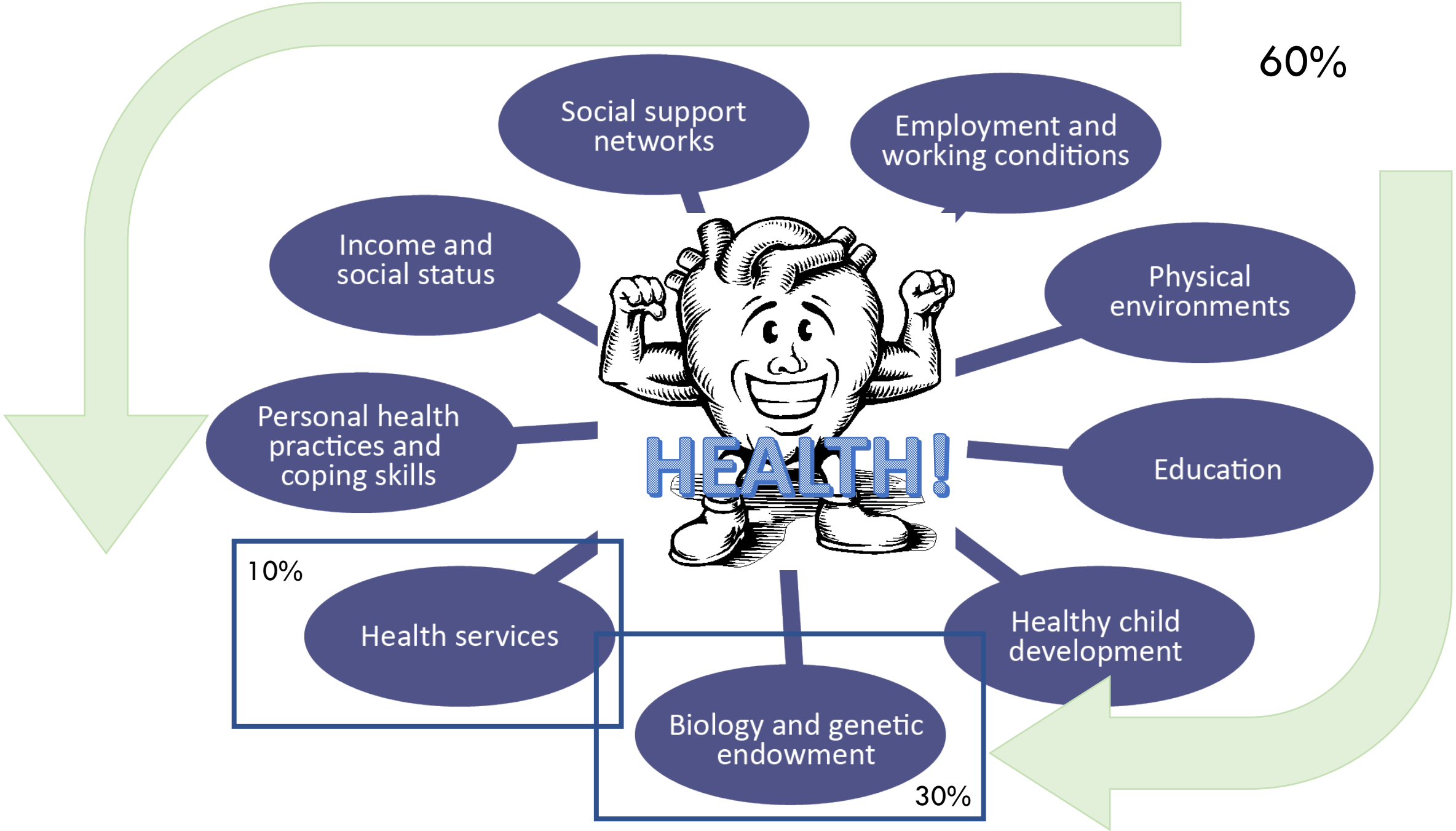
We strive to provide **compassionate care** single day. We seek t that underlie advance

patient care with coordination and to advance medicine through unrivaled education, research, and outreach in the many diverse communities we serve.

To heal, to teach, to discover and to **advance the health** of the communities we serve.

…to provide compassionate, high-value, quality care, **improving health in Western New York and beyond**, educating future health care leaders and discovering innovative ways to advance medicine.

Contributions to Longevity. Kaplan & Milstein, 2019 May;17(3):267-272. doi: 10.1370/afm.2362



Quality measures, national mandates…

- Patient-reported outcomes
  - Patient's health status, quality of life, health behavior, or experience of care
- Effectiveness measures
  - Patients receiving recommended hospital care for specific condition
  - Re-admission rates
  - Infection rates
- Cost containment

…all dependent on social circumstances

Upstream

Downstream

Social Inequities

Class
Race/Ethnicity
Immigration Status
Gender
Sexual Orientation

Institutional Inequities

Policies, Programs, and Practices in:

Government agencies
Schools
Laws and Regulations
Non-Profits
Businesses

Living Conditions

Physical Environment:
Land use
Transportation
Housing
Exposures

Economic Environment:
Employment
Income
Retail businesses
Occupational risk

Service Environment:
Health care
Education
Social Services

Social Environment:
Violence
Culture
Media and ads
Experience of social inequities

Behaviors

Smoking
Nutrition
Physical activity
Sexual behavior
Drugs and alcohol

Health Outcomes

Chronic disease
Communicable disease
Injury
Mortality
Life expectancy

In COMMUNITY

In Health Systems

Consider Root Causes

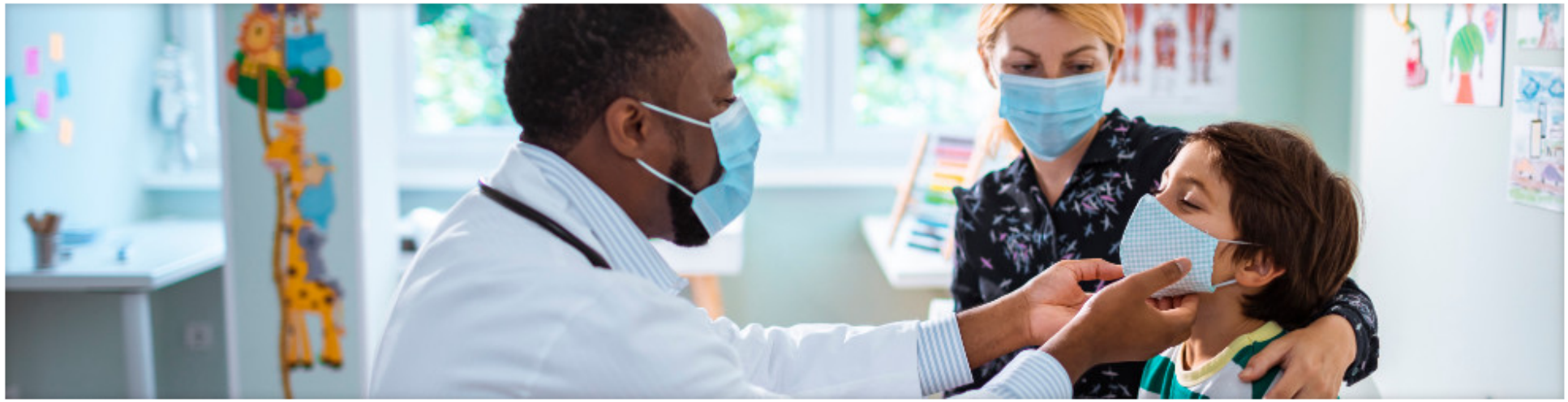
Ask yourself WHY this is the way it is! Keep digging!

Engage all levels of stakeholders in this conversation.

Use tools from quality improvement

- The Ishikawa Fishbone Diagram (IFD)
- Pareto Chart
- 5 Whys
- Failure Mode and Effects Analysis (FMEA)
- Scatter Diagram
- Affinity Diagram
- Fault Tree Analysis (FTA)

What is HEALTH EQUITY? (CDC)



Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities.[1,2]

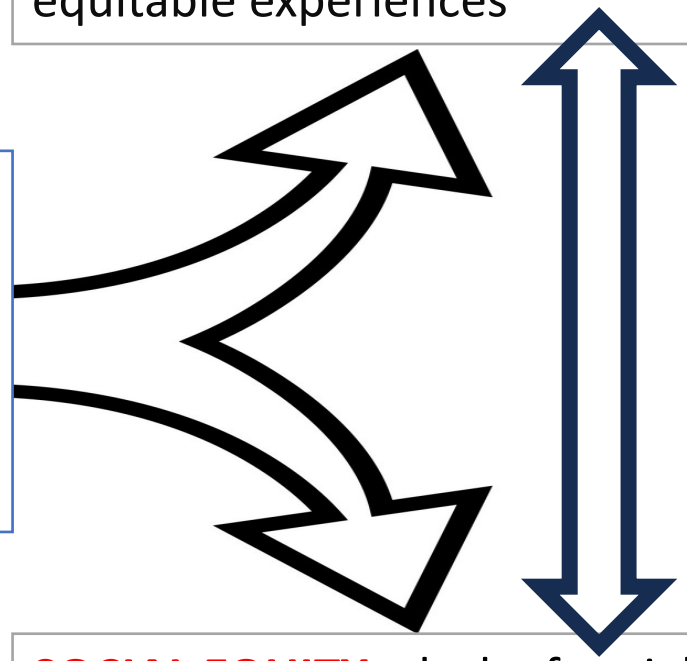
Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

Achieving health equity also requires addressing social determinants of health and health disparities. It involves acknowledging and addressing racism as a threat to public health and the history of unethical practices in public health that lead to inequitable health outcomes. The CDC prioritizes reducing health disparities among populations disproportionately affected by HIV, viral hepatitis, sexually transmitted diseases, tuberculosis, and other related conditions.

Health Equity vs Health Care Equity

HEALTH CARE EQUITY = fairness in accessing and engaging with the healthcare system and its entities. All patients should have equal access, receive unbiased care, and encounter equitable experiences

HEALTH EQUITY = The state in which everyone has a fair and just opportunity to obtain their highest level of health



SOCIAL EQUITY = lack of social, economic, and/or environmental disadvantage. Often there are inequities based on social disadvantage, racial or ethnic differences, or gender inequities.

Addressing health equity can lead to improved patient satisfaction and trust in the healthcare system, which can have positive effects on patient engagement, adherence to treatment plans, and overall health outcomes.

Collecting SOGI and REAL data and evaluating disaggregated health outcomes will identify disparities…

Now what?

Community engagement is essential in addressing health equity and is defined as collaboration between institutions and the larger communities (local, regional/state, national, global) for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity.

Goal!

Carnegie Foundation for the Advancement of Teaching. *The 2024 Elective Classification for Community Engagement*. https://carnegieelectiveclassifications.org/the-2024-elective-classification-for-community-engagement/. Published n.d. Accessed March 16, 2022.

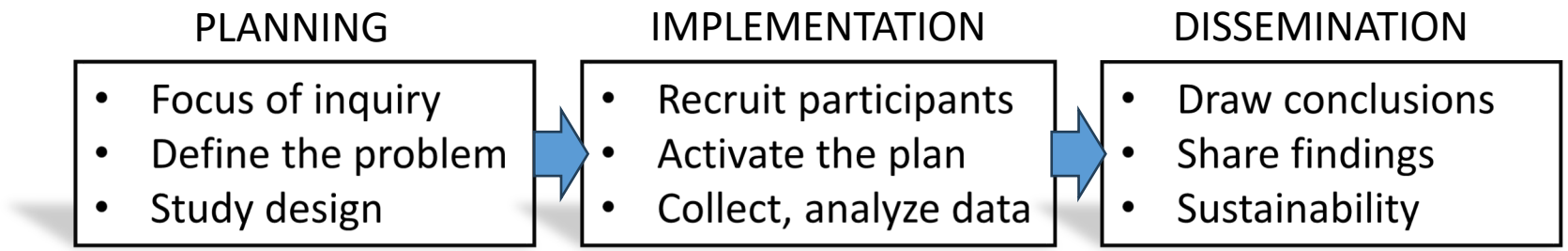
Community

KEEPS PROJECT RESPECTFUL, ACCESSIBLE, AND SOCIALLY RELEVANT

Meets community priorities
Assures community relevance and feasibility, grounds the project

Ensures effective recruitment that community members will get behind,
Ensures acceptable instruments
Level-set the results

Understandable messaging
Ownership to build sustainability
Assures conclusions are palpable



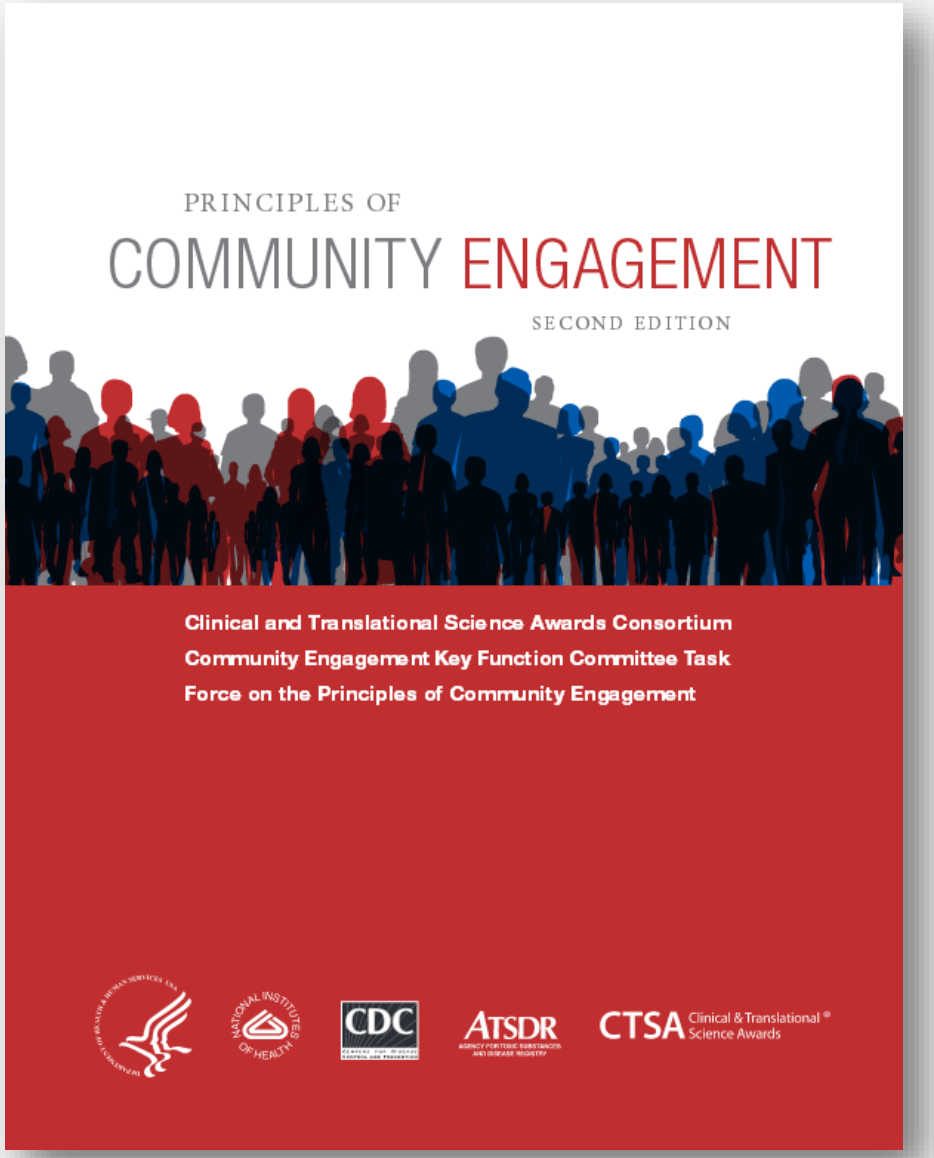
Infrastructure
Evidence Base for Interventions
Experience with funders and reporting

IRB for safe recruitment
Scientifically appropriate work
Academic rigor and processes

Build on theory
Publish findings in scientific journals
Create policy/leadership for sustainability

KEEPS PROJECT SCIENTIFICALLY SOUND AND ACADEMICALLY RELEVANT

Health Systems/Academics



Why Community Engagement?

"In general, the goals of community engagement are to **build trust, enlist new resources and allies, create better communication, and improve overall health outcomes** as successful projects evolve into lasting collaborations" (CDC, 1997; Shore, 2006; Wallerstein, 2002)

Guiding Principles of Community-Engaged Research

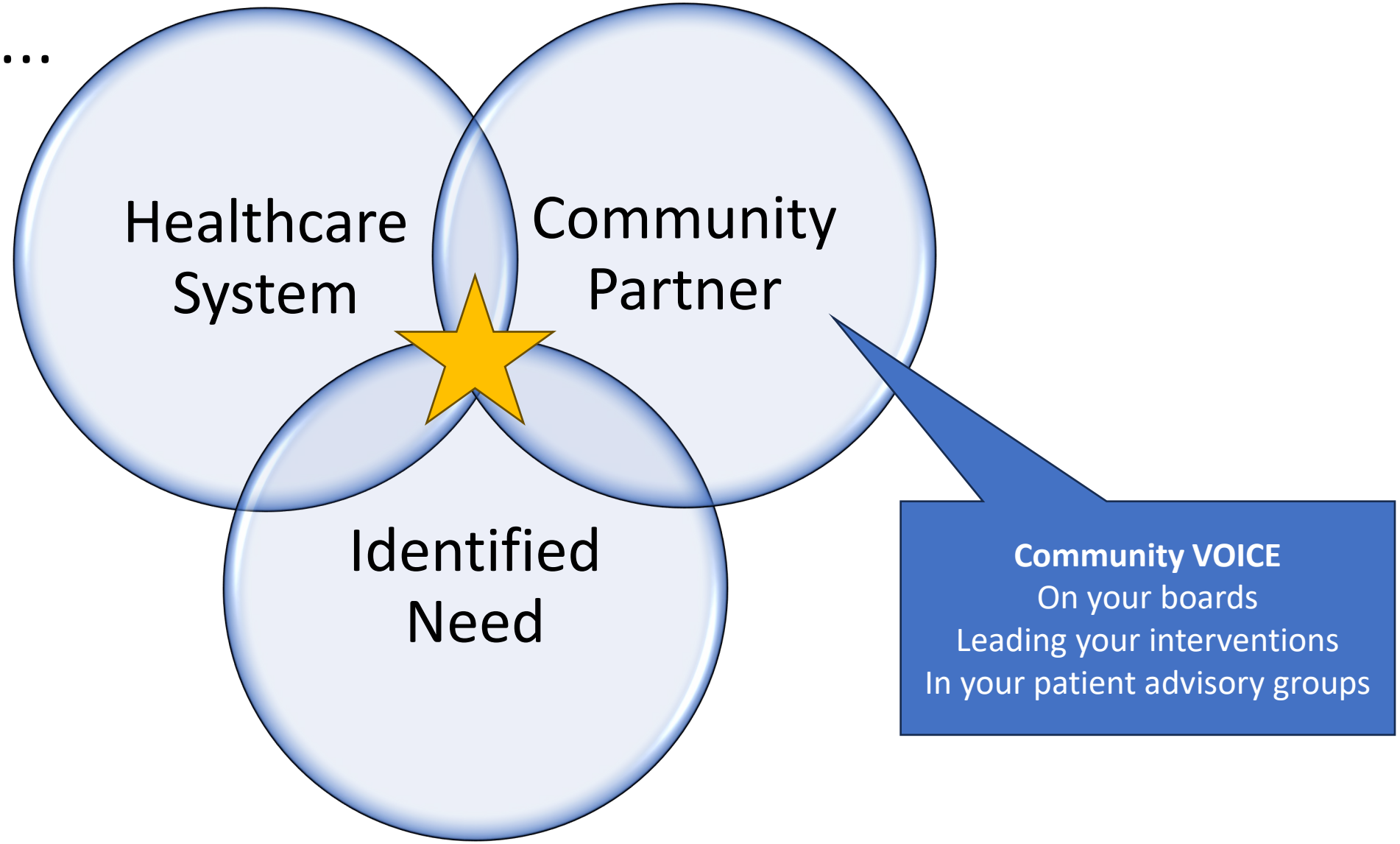
- **Long term engagement**
- **Mutual benefit**
- **Mutual respect**
- **Shared findings**
- **Enhanced community capacity**
- **Shared responsibility**
- **Evidence-based**
- **Collaborative from start to finish**
- **Responsive to community priorities and perspectives**

Developed by the University of Rochester Medical Center (URMC) Community Advisory Board, ***Approved September, 2008***

2.

There are many ways to partner with the community. Find the ways that work for you and commit to advancing your efforts.

In all we do…



…as a system or a program

IAP2 Spectrum of Public Participation

IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

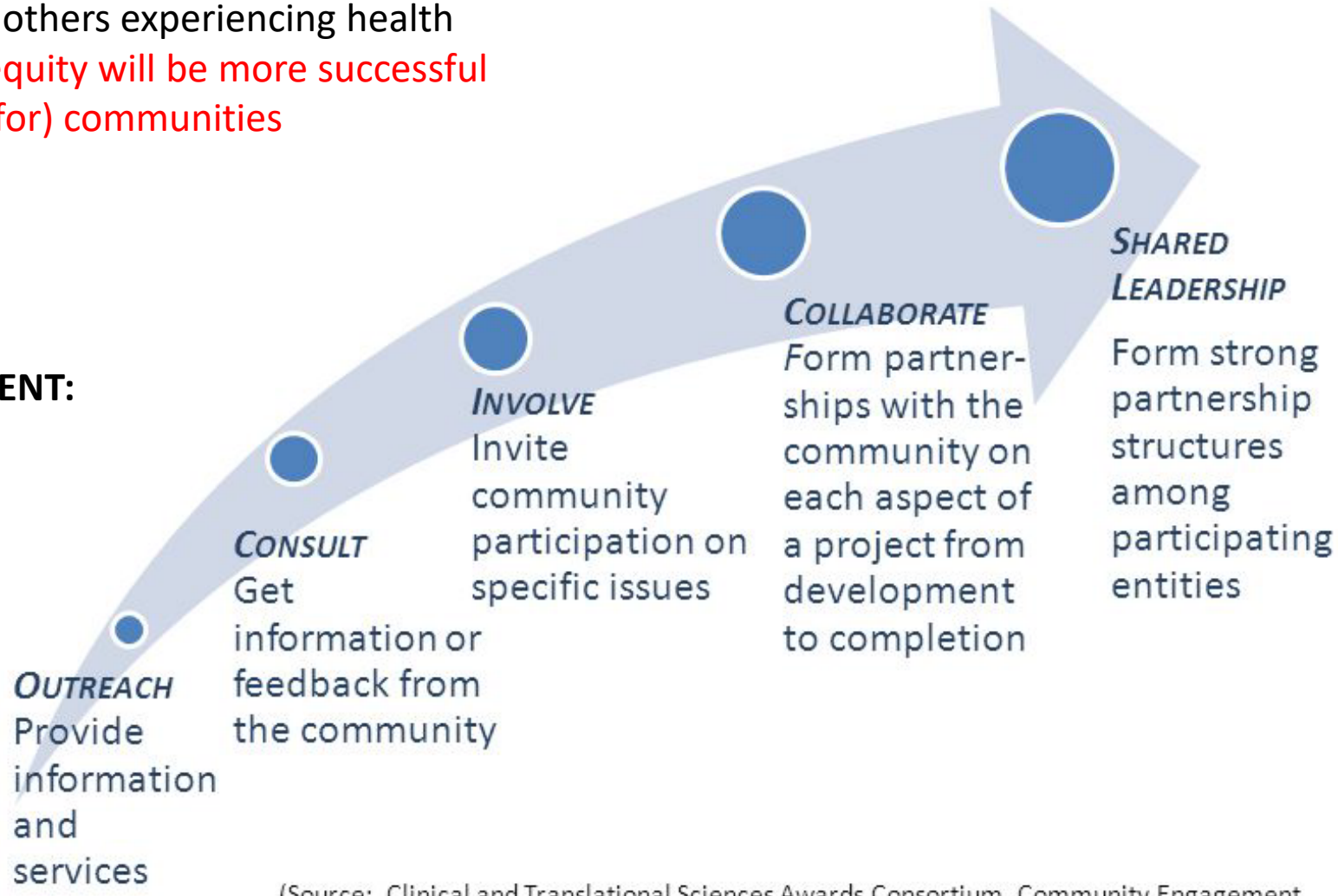
INCREASING IMPACT ON THE DECISION →

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Build trust by acknowledging the past mistakes, setting expectations and then be true to your word!

"To advance health equity, health systems must explicitly include and engage with those in poverty, communities of color, American Indians, immigrant communities, and others experiencing health inequities. Efforts to advance health equity will be more successful if they are designed **with** (not simply for) communities experiencing health disparities."

ADVANCE COMMUNITY ENGAGMENT:
Engage community partners in leadership and decision making!



(Source: Clinical and Translational Sciences Awards Consortium Community Engagement Key Functions Committee Task Force on the Principles of Community Engagement, 2011.)

https://www.health.state.mn.us/communities/practice/equityengage/community/advancingequity.html

Outreach is not the same as engagement

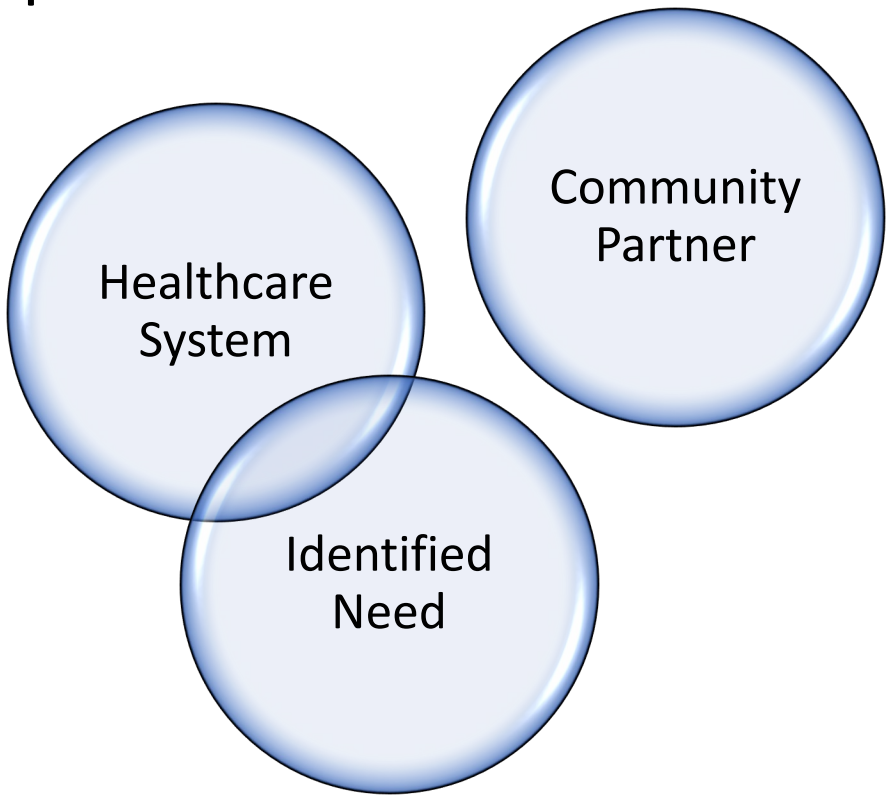
STAKEHOLDER OUTREACH VERSUS COMMUNITY ENGAGEMENT

Stakeholder Outreach	Community Engagement
Convening focus groups, surveys and town halls to gauge community concerns	Collaborating with and sharing power with communities to identify their priorities and solutions
Developing initiatives to solve problems identified by the community	Investing in community-led initiatives to develop and implement solutions; governments and organizations can provide funding, training and other resources and facilitate connections
Supporting community members' involvement, such as by providing child care and food at community meetings	Making sustained, ongoing investments that facilitate shared power, such as by hiring and adequately compensating community members to serve as community health workers, researchers or governance members
Implementing short-term solutions to address health disparities, such as initiatives to reduce the prevalence of diseases among certain subgroups in the community	Engaging in long-term capacity building, leadership development and trust building to address underlying social determinants of health and reduce long-standing inequities; evaluating the effectiveness of such efforts

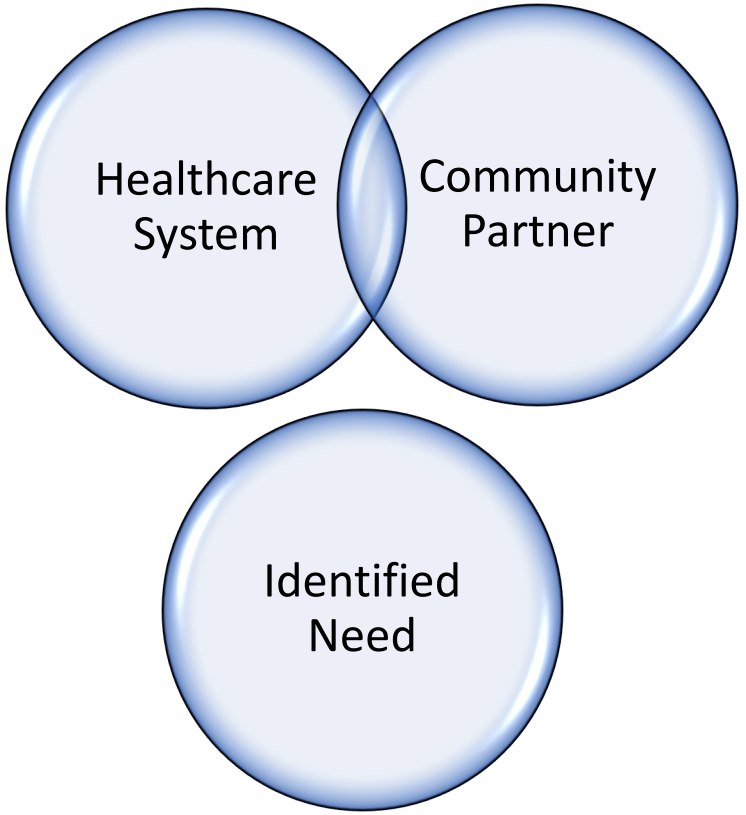
Sources: Shavon Arline-Bradley (founding principal, R.E.A.C.H. Beyond Solutions), presentation given December 2019, and key stakeholder interviews.

Operationally…

1. Healthcare system + Identified Need: Seeking community partner

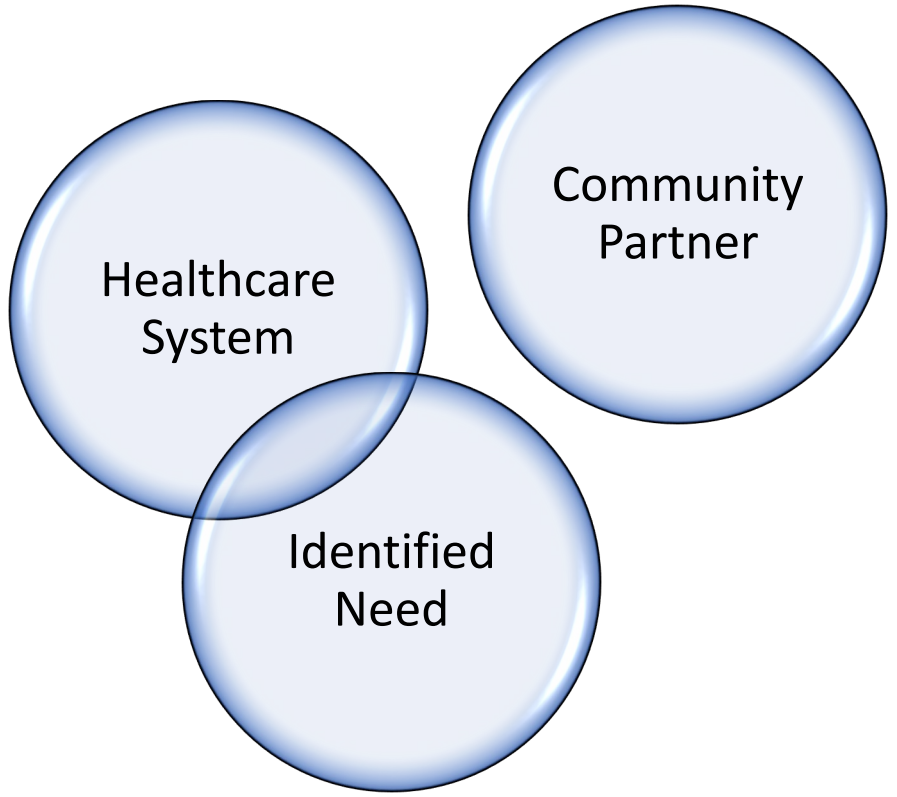


2. Healthcare system + community partner: Seeking shared needs



Seeking community partners

- Who is needed to make solutions successful?
- Who are the people already doing this work in the community?
- Do your homework:
  - Who in your institute is already working with this partner, and can they introduce you?
  - What is the history of working with this partner?
- Reach out with a low-risk, high-reward proposition



MEET WITH YOUR PARTNER 2. GET ALIGNED!

Competency/Capacity Matrix

	COMPETENCY/CAPACITY	PARTNER	PARTNER	PARTNER
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Sample Partnership Capacities

- Reference materials
- Subject matter expertise
- Lived experience
- Clinical expertise
- Grant-making expertise
- IT and technical support
- Expanded staff and volunteers
- Meeting and event space
- Data sharing, collection and analysis
- Project management expertise
- Cultural understanding
- Funding
- Brand value/reach
- Linguistic competence
- Leadership support
- Cultural competencies
- Relationships with communities
- Business connections
- Political connections
- Access to neutral/ third-party facilitators
- Social media followers/ reputational reach
- Service delivery capacity including staffing, expertise and availability

Who is needed to make this successful?

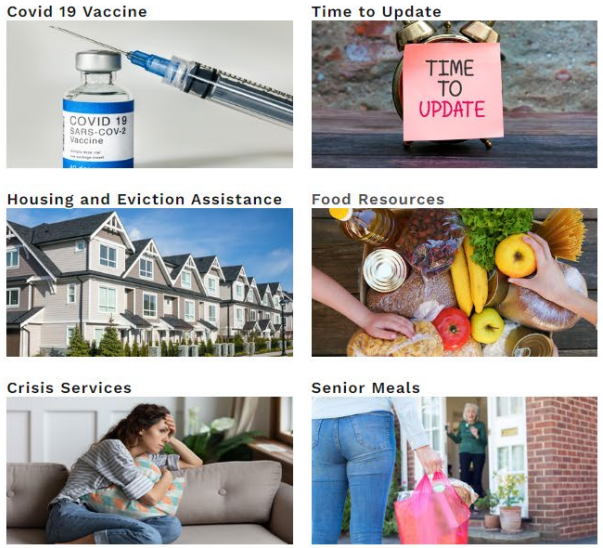
HOSPITAL COMMUNITY COLLABORATIVE

Empowering Partnerships for Health Equity

Where is the community expertise for needed competencies?

- Ask the community!

211



- Explore community coalitions
- Check community resources
- Ask community members – community advisory groups
- Ask the local public health department
- Review CHNA/CHIP
- Don't assume there is an existing coalition!

Be creative in identifying partners – Look for assets!

- Community organizations
- Faith based organizations
- Education
- Housing, transportation, food
- Government
- Public health
- Service organizations
- Local businesses
- Health care organizations

Great resource!! With examples

AVOID DUPLICATION!

Health Equity Inventory

AAMC | Center For Health Justice

Home | About Us | Our Work | Get Involved | Resources | Career Development | News

NEWS

Getting the House in Order

March 1, 2022

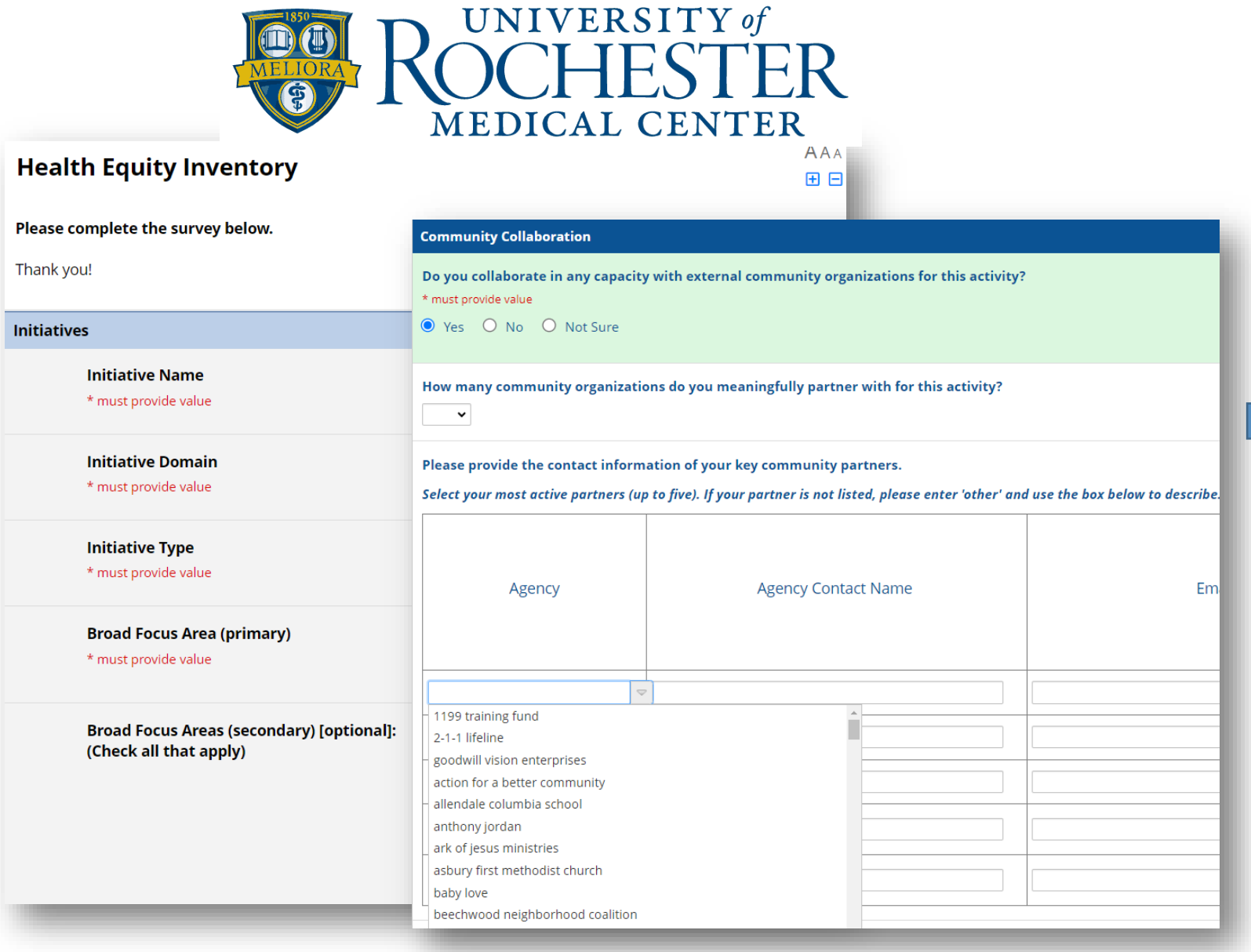
The Health Equity Inventory: A New Way to Work Together for Community Health Equity

Imagine that your neighborhood has few options for residents to purchase fresh, healthy foods. Now imagine that you run a food bank, and your clients and staff want to start a community garden to expand those options. What would you need to know to get started? The names of organizations in your community that have funding to support work on food justice would be a good place to start. You could find out about

The URMC was selected to pilot the Health Equity Inventory Tool to begin to take community engagement to the next level.

Working with:

- Eastern Virginia Medical School
- Oregon Health & Science University
- University of California, San Francisco
- University of Rochester
- Vanderbilt University Medical Center



- Reports of initiatives for URMC and partners
- Transparency and data sharing for all
- Opportunities to identify partnerships and synergies
- Opportunities to identify underserved populations and geographies
- Better coordination internally and with partners
- Build on existing partnerships to deepen engagement

Health Equity Inventory = tool for deeper engagement

Examples: Addressing Health-Related Social Needs

SCREENING

Urmc Sdoh Mychart Screening

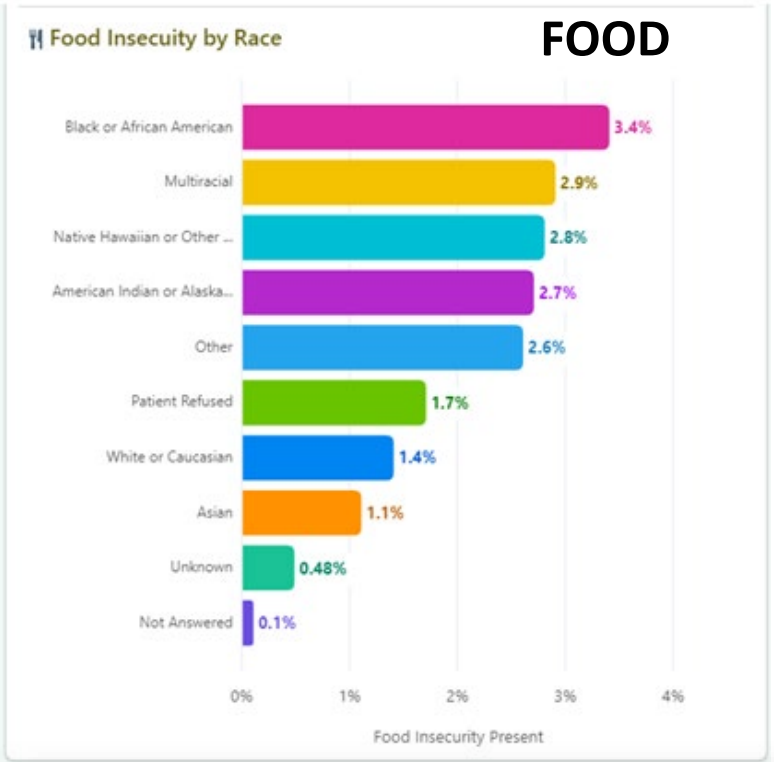
Question	7/18/2022 2:05 PM EDT - Filed by Patient
Within the past 12 months, you worried that your food would run out before you got the money to buy more.	Never true
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Never true
In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?	No
In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?	No
In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?	No
In the last 12 months, how many places have you lived? (range: at least 0)	1
In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?	No

UR MEDICINE | STRONG MEMORIAL HOSPITAL

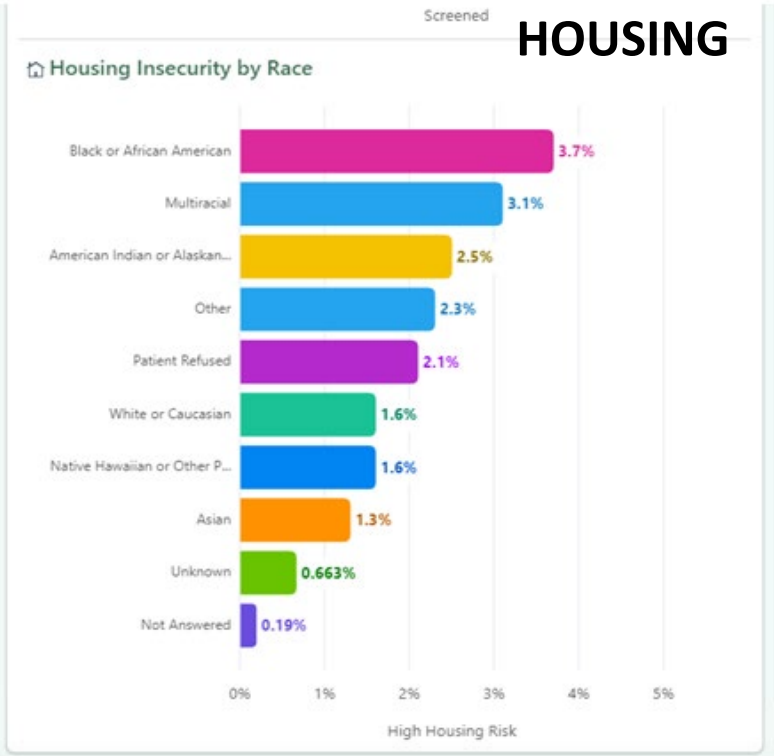
MEDICINE of THE HIGHEST ORDER

Slicer Dicer DASHBOARD of Social Drivers of Health (in epic) – Early in the collection of data

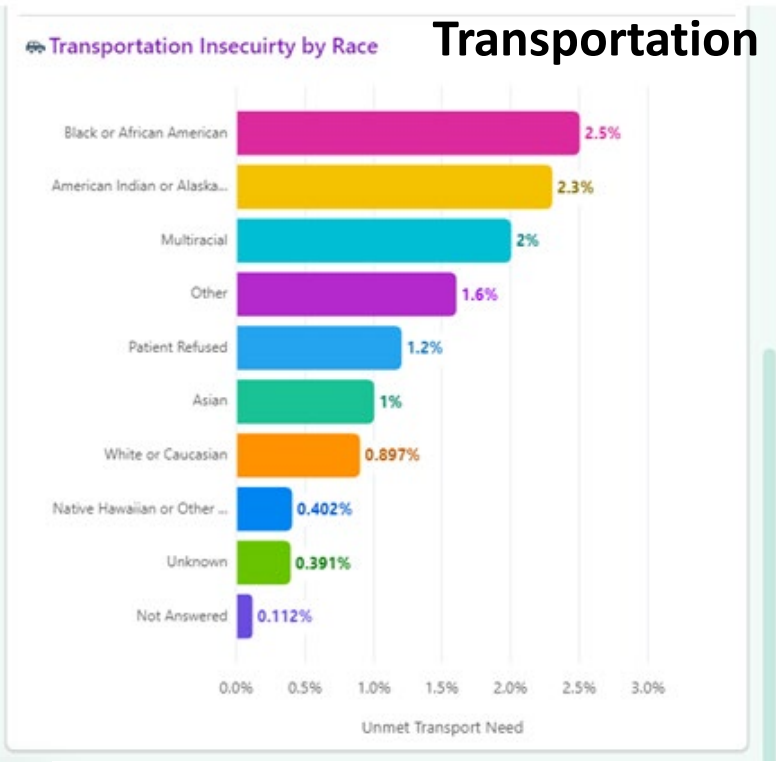
FOOD

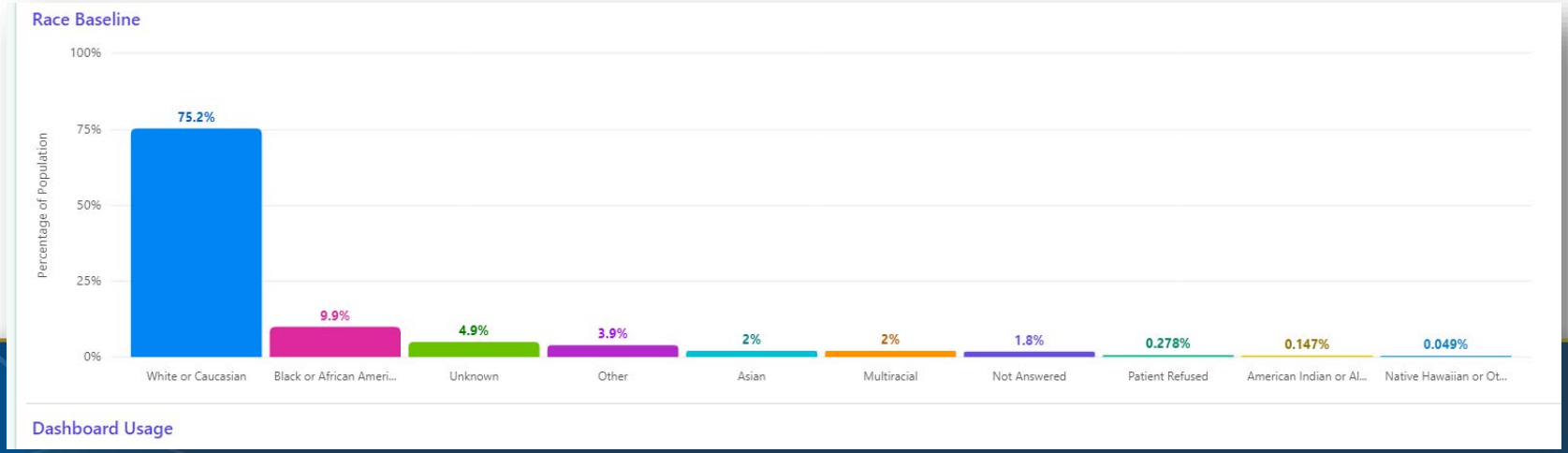


HOUSING



Transportation





HEALTH EQUITY & ANTI-RACISM TECHNOLOGY PROGRAM

UNIVERSITY of ROCHESTER MEDICAL CENTER

Hopelink at Shelter Cove

URMC Partnership with DePaul Community Services

TRANSITIONAL SUPPORTIVE HOUSING

UR MEDICINE | STRONG MEMORIAL HOSPITAL

MEDICINE *of* THE HIGHEST ORDER

Our Story

Hopelink at Shelter Cove opened in January 2016 as a non-licensed transitional supportive setting

- Goal was to develop a transitional supportive housing model for inpatient individuals unhoused or experiencing housing instability.
- In 2015, a community partner, DePaul Community Services, was identified and a partnership was secured in 2016.
- Our partner had housing expertise and available property; there was secured hospital funding and partnership with our URM Home Care to provide a transition from hospital to community.

Currently 10 beds

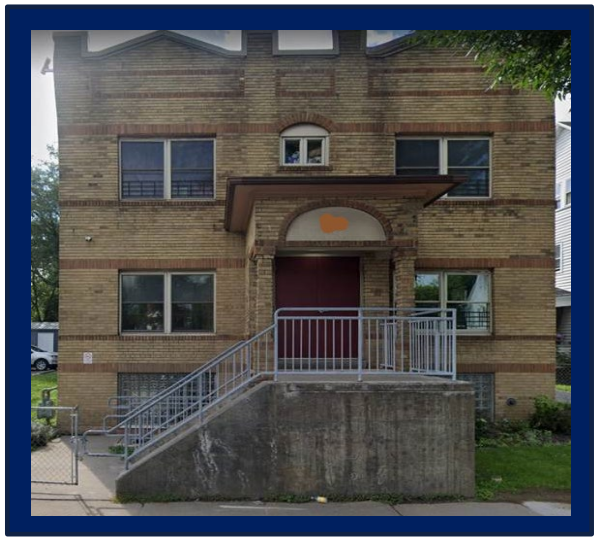
CATHOLIC CHARITIES FAMILY & COMMUNITY SERVICES

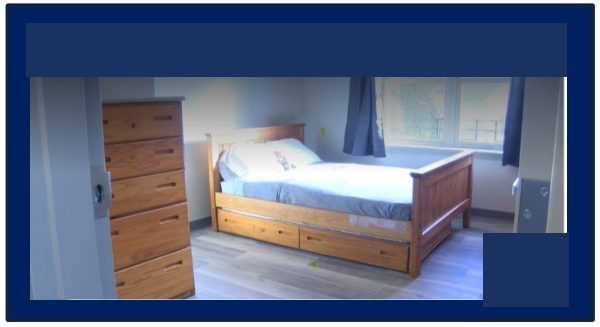
SANCTUARY HOUSE AND FRANCIS CENTER

URMC PARTNERSHIP WITH CCFCS

TRANSITIONAL SUPPORTIVE HOUSING IN COMMUNITY SHELTER SETTINGS

Sanctuary House and Francis Center





- Services are provided at two existing community shelters: the Francis Center and Sanctuary House. Francis Center serves men, and Sanctuary House serves women, families, transgender and non-binary individuals.
- Transitional supportive housing programs emphasize acceptance and support.
- Both facilities are handicap accessible and are located within the City of Rochester with access to public transportation and/or assistance with medical taxis.
- The facilities are staffed 24 hours a day, 365 days a year. As part of the program, patients receive three nutritious meals a day. On-site case management is provided to assist with referrals to community-based services, medical appointments, transportation, etc.

Currently 25 beds

Community Partners

We cannot do this work alone. Below is a partial list of the community partners we work alongside to benefit those we serve.

- Monroe County Department Human Services (DHS)
- City of Rochester
- Homeless Services Network (HSN)
- Partners Ending Homelessness (local Continuum of Care)
- Coordinated Entry
- Coordinated Care Services (CCSI)
- Providence Housing
- University of Rochester Medical Center (URMC)
- Regional Health Reach
- Office of Temporary Disability (OTDA)
- Monroe County Department of Public Health (DPH)
- Homeless Housing and Assistance Program (HHAP)
- Department of Corrections and Community Supervision (DOCCS)
- Local Community Based Organizations (CBO's)

SANCTUARY HOUSE AND FRANCIS CENTER

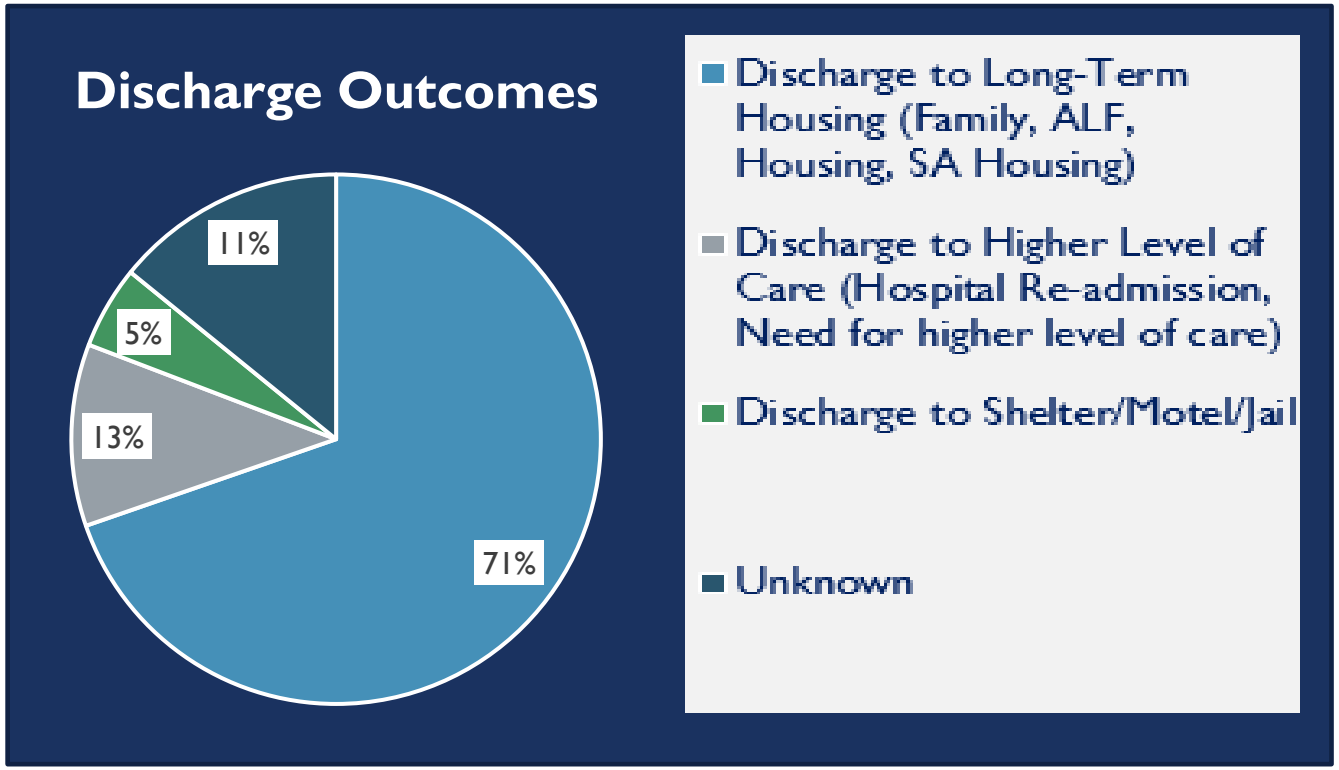
URMC Partnership with CCFCS

TRANSITIONAL SUPPORTIVE HOUSING PROGRAM

Current Data: June 2021 through March 2024

Total Referrals	Average Length of Stay at CFC Shelters
824	48 Days

Accepted Referrals	Discharged to Long Term Housing
414	71%



We had the ability to screen for food insecurity, but we were missing a community partnership and workflow to help us **immediately** connect patients in **urgent need** to nutritious and affordable food options **on-site**.

Foodlink
NOURISHING LIVES

1850 MELIORA UR MEDICINE

The Department of Social Work and Patient & Family Services, the Health Equity Program Support Office (HEPSO), and Food and Nutrition have forged a partnership with FoodLink to operationalize food pantry pilots. The partnership includes piloting a referral-based, emergency food pantry for patients identified as food insecure at an appointment or during their hospital stay.

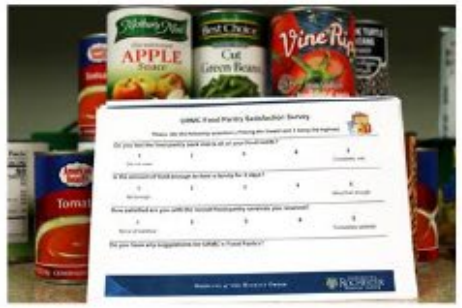
Patients here for a Primary Care Visit

Provider Screens for Food Insecurity during visit and creates a referral order in the Electronic Medical Record

Patient receives a printed voucher

Patient goes to patient discharge to pick up their bag(s)

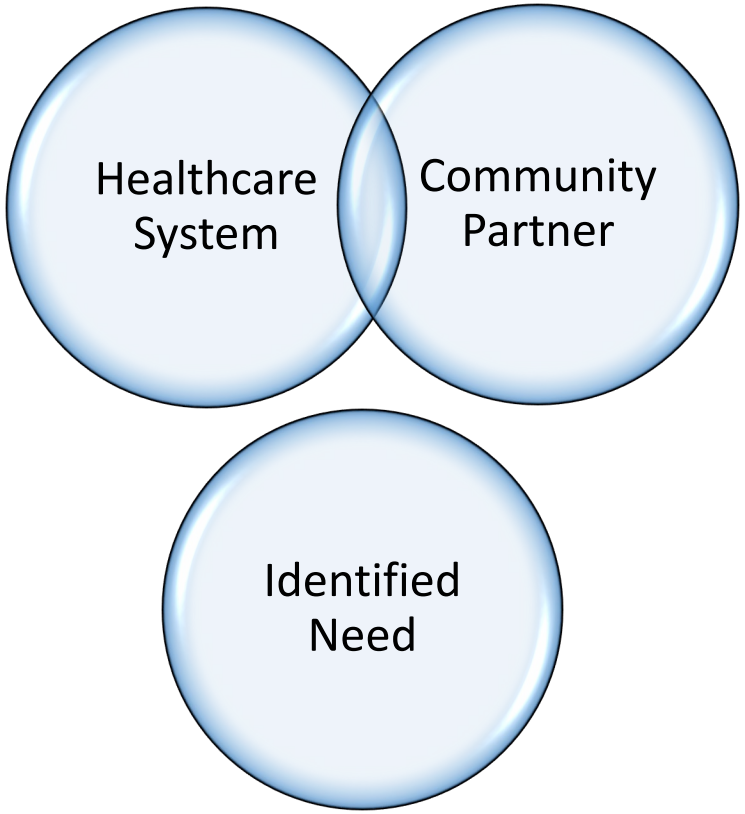
Patient survey included in bags



Financing has expanded through grants and now several food pantry sites across our network.

Defining Shared Needs

"We have an amazing partnership, how to we create meaningful work?"



Community Health Improvement Workgroup

UR MEDICINE

Strong Memorial Hospital

Highland Hospital

ROCHESTER REGIONAL HEALTH

Rochester General Hospital

Unity Hospital

Monroe County Department of Public Health

+ Several community-based organizations

Meeting monthly since 2000, for the CHNA/CHIP process but little discussion about governance or mission.

chiw
COMMUNITY HEALTH IMPROVEMENT WORKGROUP

Mission: To improve the health and wellness of individuals and families of Monroe County by addressing prioritized needs and inequities through sustainable systems change built on collaboration and supported by shared resources.

Communication Strategy:

Meetings 90 minutes monthly, agenda ahead of time
Continue virtually with occasional in-person
Minutes to participants and senior leadership
Newsletter to anyone interested distributed monthly

Funding Strategy:

Annual budget proposed by the leadership team and approved by core members. Hospitals are invoiced reflective of their percent of hospital discharges in the county.

Leadership Team:

Chair, Theresa Green, PhD, MBA
Coordinator, Sarah Verna, MPH

Core Members:

One representative from each of 4 hospitals
One representative from dept of Public Health

Advisory Members:

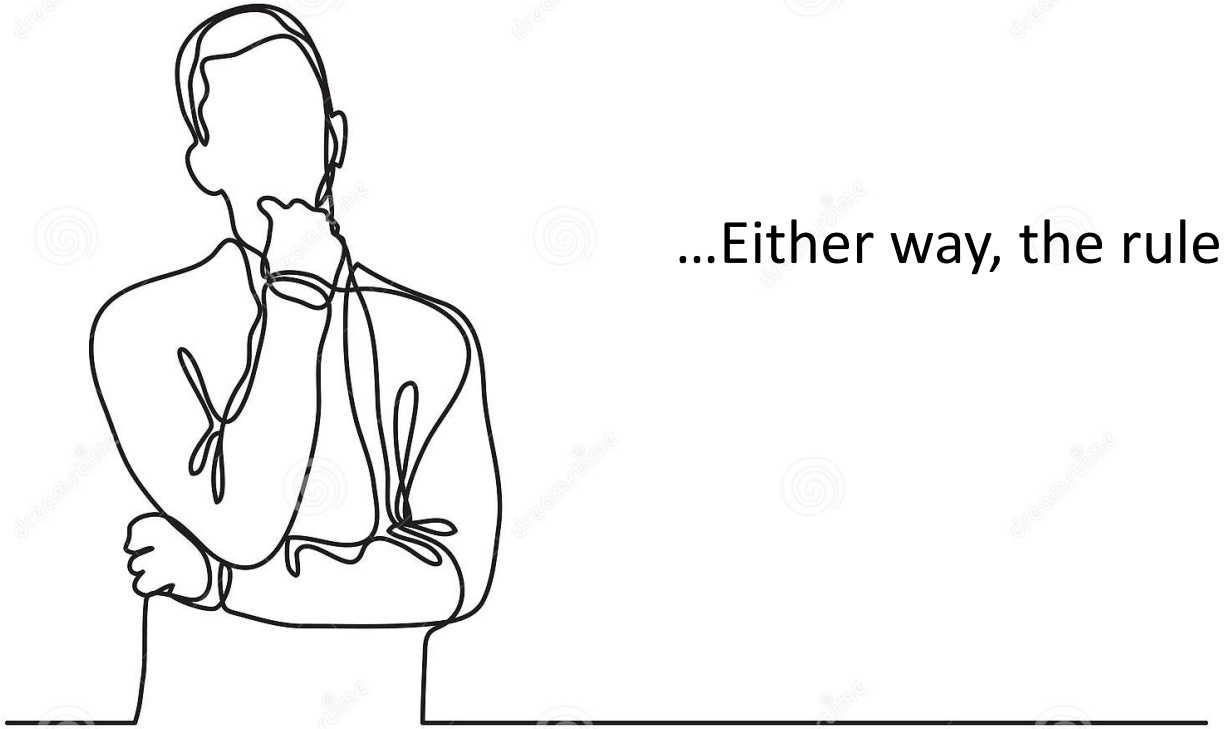
City Government, Medical Society, AA and Latino Health Coalitions, United Way, FQHC, Several CBOs, regional planning agency, RHIO, etc.

3.

Community engagement should be intentional: there should be a plan, a process, and an evaluation or reflection for the partnership

Partnership for Solutions

You might have a specific area of concern that is driving your community outreach, or you might be trying to decide what the priority problem is…



…Either way, the rules and processes are the same.

AHA CENTER FOR HEALTH INNOVATION

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Hospital Community Collaborative Curriculum

HCC | Hospital Community Collaborative Curriculum

This interactive model is designed to provide the flexibility of an asynchronous program, while maintaining the opportunity for ongoing peer-to-peer learning.

Whether you're part of a hospital, health system, public health department or community-focused organization, the HCC is here to provide the tools, resources, exercises and network needed to take your collaborative efforts to the next level.

The HCC offers six modules featuring video narratives from a network of leading community health experts, as well as readings and resources highlighting the leading practices for effectively managing community health partnerships. Focusing on different topics and themes, each module provides the building blocks necessary to master the process of collaboratively developing solutions with your community health partners.

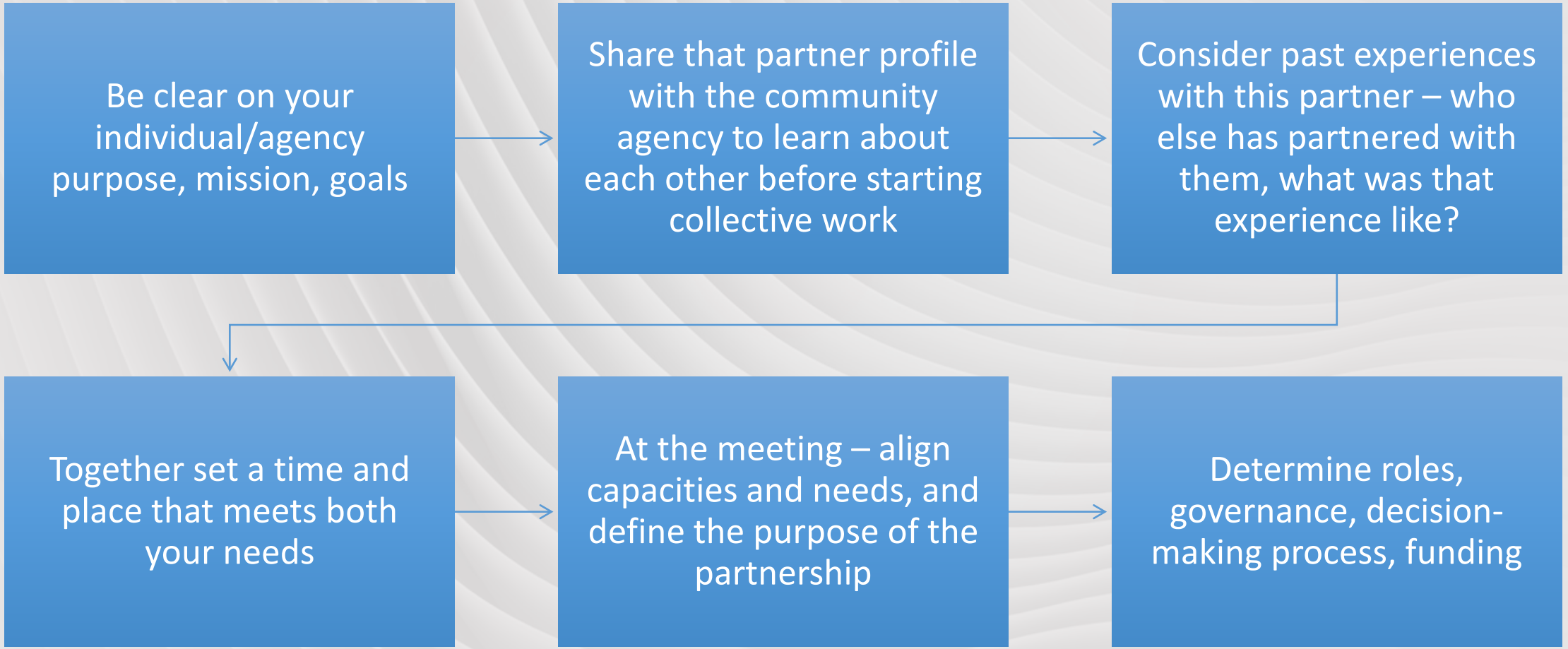
Module 1: Get to know your partner
Module 2: Assure achievability of shared goals
Module 3: Consider the data
Module 4: Strengthen community engagement
Module 5: Business case and sustainability
Module 6: Demonstrate impact – Tell the partnership story!

HOSPITAL COMMUNITY COLLABORATIVE
Empowering Partnerships for Health Equity

- Enroll
- About
- Curriculum
- Virtual Coaching Sessions
- Teams
- Resources

American Hospital Association™
Advancing Health in America

1. Get to know your partner



GET STARTED

15-MINUTE ACTIVITY

Develop Your Partner Profile

Before you meet, each partner should take stock of their own organization's purpose, goals, operating practices, culture, and vocabulary. These are the key building blocks of your partnership alignment and ability to collaborate effectively. Take a look at the questions and prompts below with the goal of being able to provide a high-level response to each question.
You can jot down your responses if you'd like, and keep your answers to a few sentences or bullets per question. You can also share a link with one other.

WHOM DO YOU SERVE?

- What's your role/mission?
- Where do you operate?
- Whom do you serve? (socioeconomically, demographically, by health status, social need, payer)

WHAT DO YOU DO?

- Purpose?
- Timeframe?

WHY DO YOU DO IT?

- What need are you fulfilling?
- How does it support your organization's strategic goals?

HOW DO YOU DO IT?

- Deliver services?
- Operating/leadership structure?
- Key operational terms and definitions?

WHAT ARE THE UNIQUE CONTRIBUTIONS YOU BRING TO THIS PARTNERSHIP?

- Technical?
- Relational?
- Clinical?
- Other?

WHY ARE YOU PURSUING THIS PARTNERSHIP?

- What need are you fulfilling?
- How do you know this is a need?
- How does this partnership goal support your organization's strategic priorities?
- What are the revenue/funding opportunities that factor into this partnership?

HOSPITAL COMMUNITY COLLABORATIVE
Empowering Partnerships for Health Equity

Plan for engagement of external partners

Add a partner to the internal team

- Reach out to potential partners and explain your request including why you selected them to join you
- Be flexible and accommodating
- Collaborate on the agenda and outline clear expectations for all

Join an existing coalition

- Reach out to the leadership to describe your needs and discuss options, be humble and accommodating

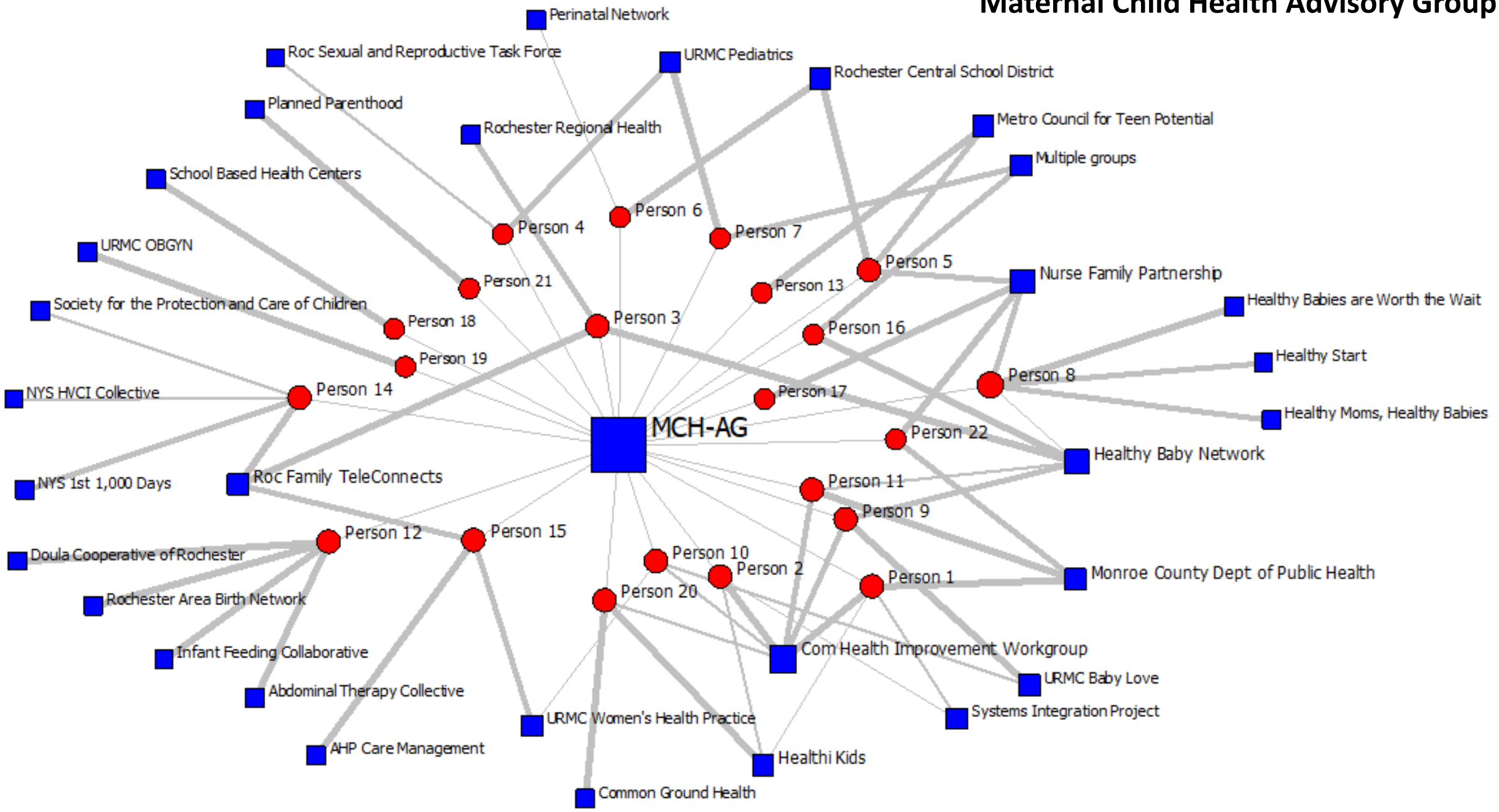
Create a new coalition

- Kick off meeting with new partners, maybe in the community
- Retreat or synergy meeting option

Maternal Child Health Advisory Group

- An advisory group of content experts for the CHIW
- Primary goal: enhance collaboration with other programs, providers, agencies, and community members to address key social drivers that impact the health of women, infants, children, and families across the life course.
- Since its inception in 2020, the group has grown to over 100 members from more than 34 organizations or departments across Monroe County. The MCH-AG has met quarterly for the past five years via Zoom. To encourage transparency and inclusiveness, meetings are open to all.
- Each meeting starts with 15-minute break-out discussions in groups of 5-10 to get to know each other
- Members of the group are invited to present for 15 minutes on their agency or current work

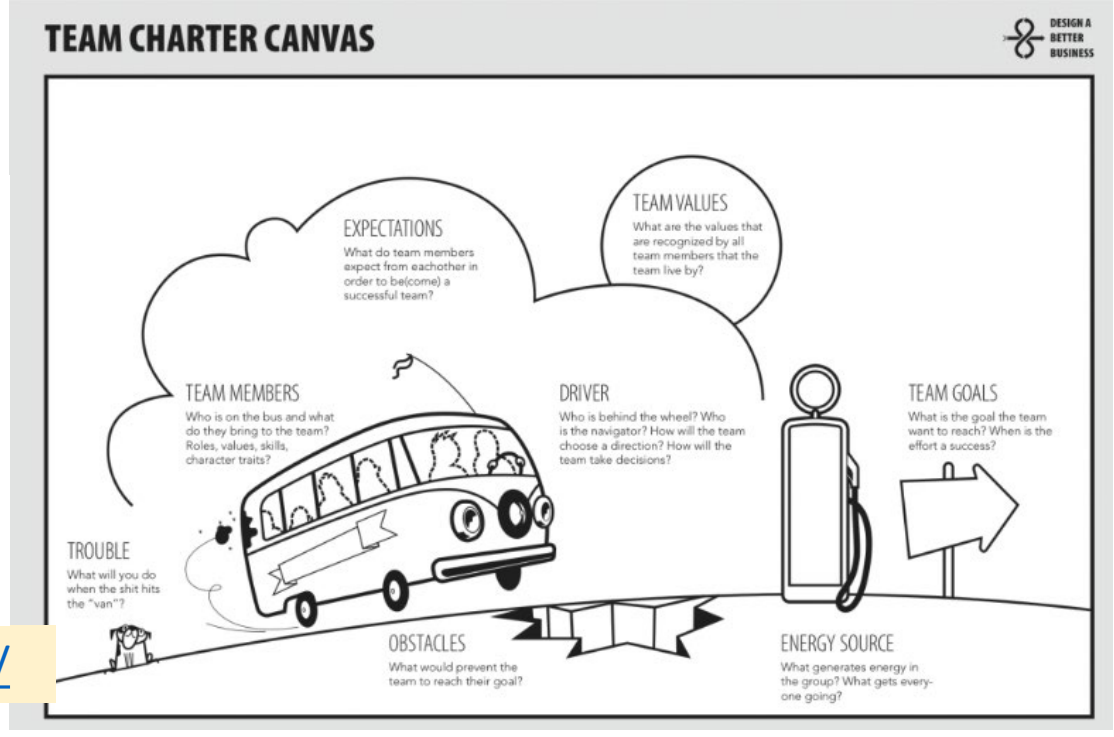
Maternal Child Health Advisory Group



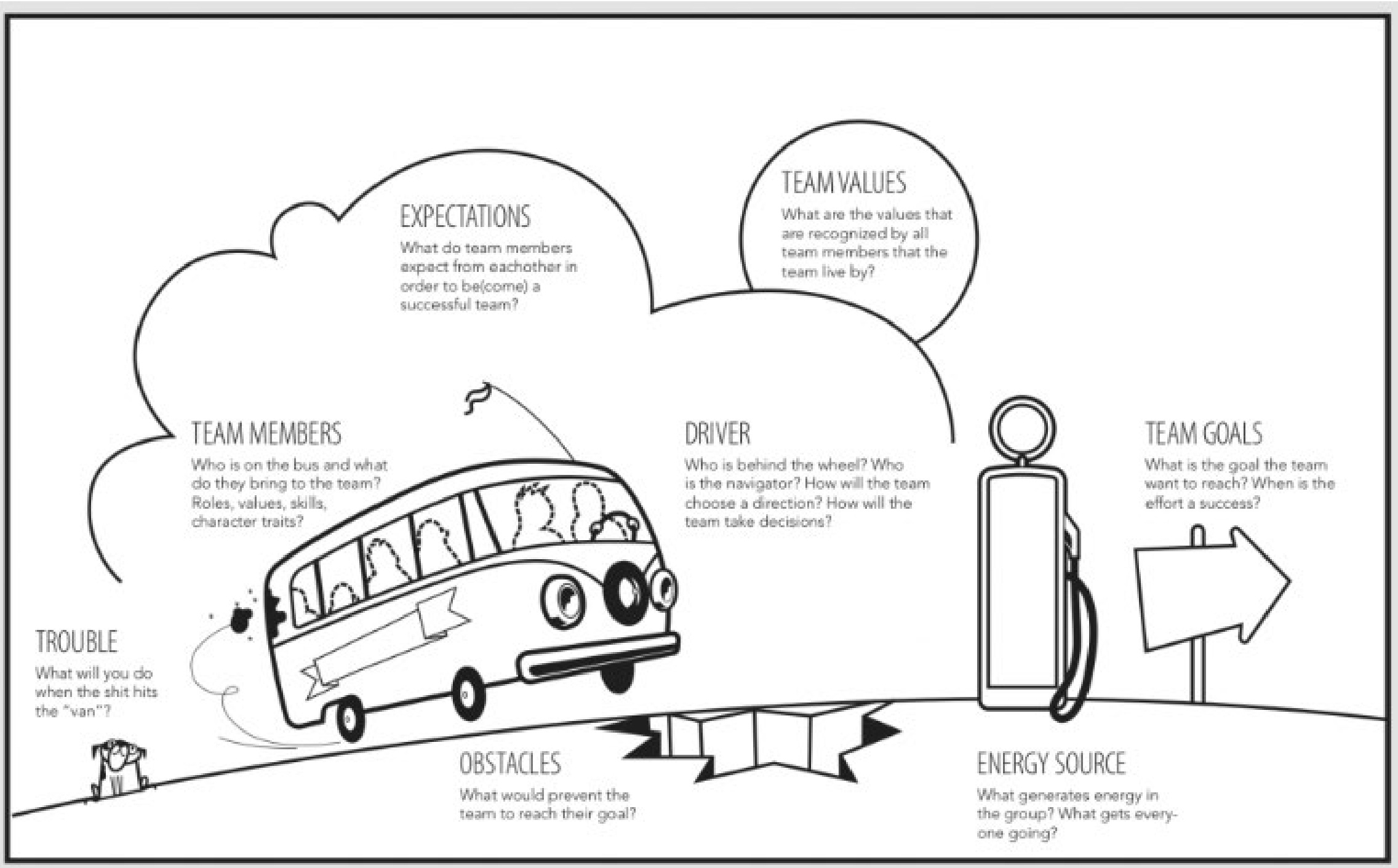
2. Assure achievability of shared goals

Develop a **TEAM CHARTER**

- HOW will you agree on your goals, expectations and values?
- How will you deal with challenging situations?
- What is the goal of the partnership?



https://designabetterbusiness.com/2017/08/24/team-charter-canvas/


EXPECTATIONS
What do team members expect from eachother in order to be(come) a successful team?
TEAM VALUES
What are the values that are recognized by all team members that the team live by?
TEAM MEMBERS
Who is on the bus and what do they bring to the team? Roles, values, skills, character traits?
DRIVER
Who is behind the wheel? Who is the navigator? How will the team choose a direction? How will the team take decisions?
TEAM GOALS
What is the goal the team want to reach? When is the effort a success?
TROUBLE
What will you do when the shit hits the "van"?
OBSTACLES
What would prevent the team to reach their goal?
ENERGY SOURCE
What generates energy in the group? What gets everyone going?

Team Goal

- What is the goal that the team wants to reach? When will the team know they have succeeded?
- Each member should clearly see how their partnership contributes to the goal

SMARTIE GOAL	
S – Specific	What do you want to do?
M – Measurable	How will you track your progress?
A – Attainable	How will you do it?
R – Relevant	How is this relevant to each partner's mission?
T – Time-Bound	When do you want to do it?
I – Inclusive	What new perspectives could you bring into the project?
E - Equitable	Can you change the goal to incorporate equity and inclusion

HCC Data-Use Road Map

USING DATA TO DRIVE CHANGE

3. Consider the data

1. BENCHMARK

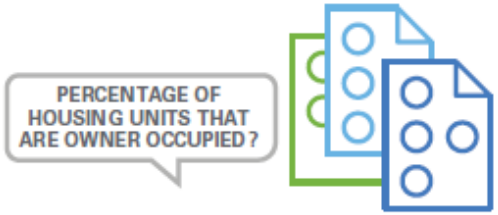
WHAT PROBLEM ARE YOU SOLVING IN YOUR POPULATION?

WHAT IS YOUR BASELINE FOR CHANGE?

WHERE CAN YOU FIND THESE DATA?

2. EVALUATE

WHAT WILL YOUR KEY PERFORMANCE INDICATORS BE?



WHAT DATA SOURCES WILL DEMONSTRATE YOUR KPIs?

HOW OFTEN WILL YOU MEASURE?

3. COMMUNICATE

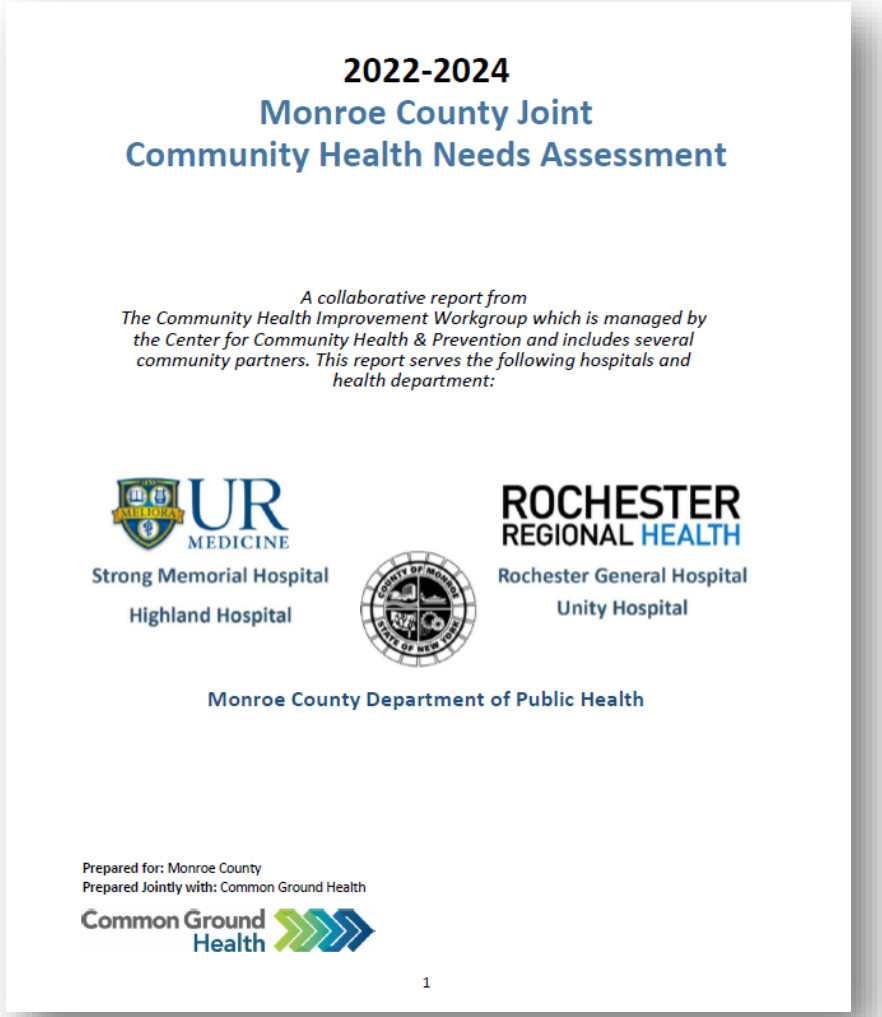
WHAT DOES SUCCESS LOOK LIKE? DESCRIBE IT.

WHAT ARE THE PROGRESS MEASURES AND OUTCOMES THAT WILL DEMONSTRATE THIS IMPACT STORY?

HOSPITAL COMMUNITY COLLABORATIVE

Empowering Partnerships for Health Equity

Population Health Data



2022-2024

Monroe County Joint

Community Health Needs Assessment

A collaborative report from
The Community Health Improvement Workgroup which is managed by the Center for Community Health & Prevention and includes several community partners. This report serves the following hospitals and health department:

UR MEDICINE
Strong Memorial Hospital
Highland Hospital

ROCHESTER REGIONAL HEALTH
Rochester General Hospital
Unity Hospital

Monroe County Department of Public Health

Prepared for: Monroe County
Prepared Jointly with: Common Ground Health

Common Ground Health

1

US Census Bureau

American Community Survey

CityHealth Dashboard

Healthy People 2030

County Health Rankings & Roadmaps

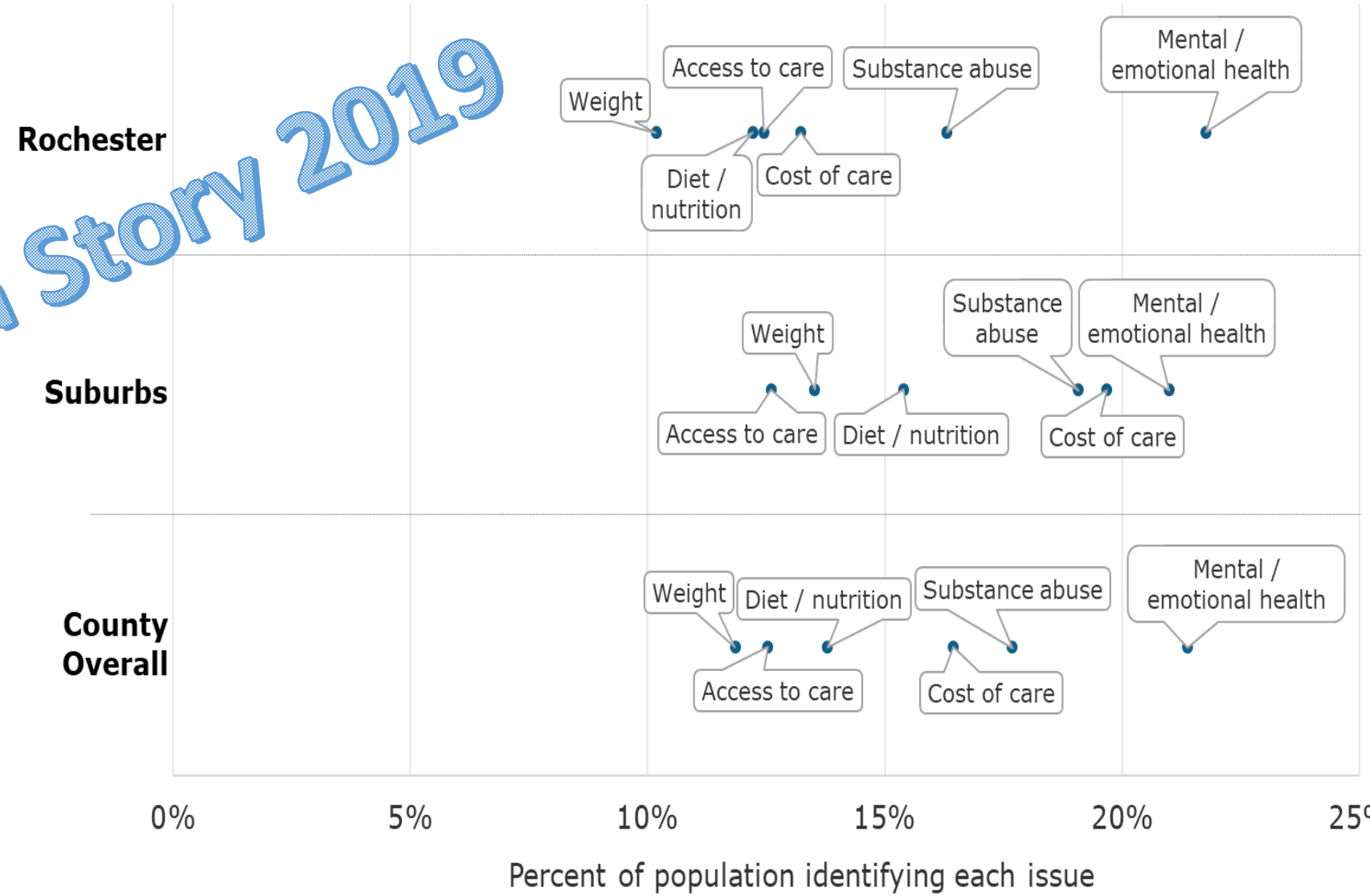
New York State Prevention Agenda Dashboards

Electronic Medical Record/RHIO

Community Health Needs Assessments

https://www.urmc.rochester.edu/community.aspx

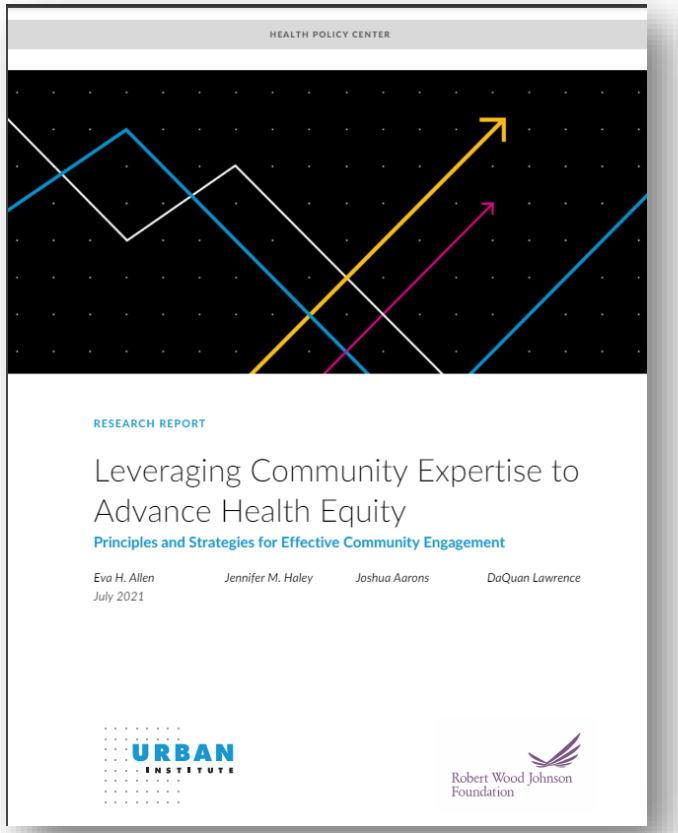
Most important health concern that county should focus on for adults (Monroe County)



Source: My Health Story survey 2018; Analysis by Common Ground Health incorporates weighting to reflect demographic of Finger Lakes region

4. Strengthen Community Engagement

Move beyond data to learn what is really going on in your community



Leveraging Community Expertise to Advance Health Equity 2
by the Urban Institute

Four guiding principles:

1. Community engagement relies on establishing trust
    - Be humble, listen, and act on feedback.
    - Be transparent.
    - Partner with trusted community leaders and CBOs.
2. Community engagement requires sufficient and flexible funding and cross-sector support.
3. Community engagement must be continuous and sustained
4. Community engagement should pay explicit attention to eliminating structural racism.
    - Hire from the community.
    - Address participation barriers.
    - Address racism inside and outside governments and organizations.

Be TRUSTWORTHY

AAMC | Center For Health Justice

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Home / Trustworthiness / The Principles of Trustworthiness

MENU

AAMC Center For Health Justice

The Principles of Trustworthiness Toolkit

This toolkit of materials is for organizations to download and use to facilitate discussions within their communities, develop relationships with a broad coalition, and track lessons learned. It includes the kinds of questions, discussions, and activities that will help an organization and its community to unpack the Principles of Trustworthiness, explore how they come to life locally, and determine what local actions might be taken to demonstrate trustworthiness.

These resources can be used to help build vaccine confidence as part of the AAMC's cooperative agreement with the Centers for Disease Control and Prevention (CDC). Learn more about this effort at VaccineVoices.org.

- Toolkit at a Glance: 10 Principles of Trustworthiness (PDF)
- Video Guide: 10 Principles of Trustworthiness (PDF)
- The Principles of Trustworthiness Community Video
- The Principles of Trustworthiness Community Video (Spanish Subtitles)
- The Principles of Trustworthiness Orientation Video
- Interactive Discussion Guide (Word)
- Discover Your Community via Appreciative Inquiry (PDF)
- Community Engagement Action Guide (Word)
- Community Engagement Reflection Guide (PDF)

The Principles of Trustworthiness

Since 2015, the AAMC has produced an annual series of Community Engagement Toolkits in collaboration with our members and their communities. These toolkits provide unvarnished community perspectives on crucial issues and views about how our members can be better partners.

The AAMC Collaborative for Health Equity: Act, Research, Generate Evidence (CHARGE) — the AAMC's national collaborative of health equity scholars, practitioners, and community partners — gathered perspectives from a diverse set of 30 community members from across
trust, COVID-19, and clinical trial participation.

These 10 Principles of Trustworthiness integrate local perspectives with
community engagement to guide health care, public health, and other
demonstrate they are worthy of trust. The AAMC Center for Health Justi
support organizations right now and in the future as they partner with co
sectors that serve them to develop ways to shift our society toward heal

10 Principals of Trustworthiness

1. The community is already educated; that's why it doesn't trust you.
2. You are not the only expert.
3. Without action, your organizational pledge is only performance.
4. An office of community engagement is insufficient.
5. It doesn't start or end with a community advisory board.
6. Diversity is more than skin-deep.
7. There's more than one gay bar and "Black church" in your community.
8. Show your work.
9. If you're gonna do it, take your time, and do it right.
10. The project may be over, but the work is not.

5. Business Case and Sustainability

Sustainability Factors to consider:

- Identify key internal experts and influencers to further your cause
- Find external “partners of the future”
- Discover new funding sources and recurring revenue
- Gain leadership and board support for the efforts

HOSPITAL COMMUNITY COLLABORATIVE
Empowering Partnerships for Health Equity

HOSPITAL COMMUNITY COLLABORATIVE

Empowering Partnerships for Health Equity

PARTNER PLEDGE

We, (organization names), are working together to (state your intervention goal) in (state your community) by (set a timeline and deadline).

To fulfill our goals within the timeline established and to ensure the sustainability of our intervention, we commit to the following:

1) **Meeting (frequency)**
2) **Bringing new partners to the table, including those from our respective organizations and communities who will help advance our goals**
3) **Defining, tracking and reporting metrics to our management, champions, funders, advocates and community (frequency)**
4) **Identifying ongoing sources of funding**
5) **Gaining management recognition and support from our respective organizations**
6) **Other**

Signature

Name, Organization 1

Signature

Name, Organization 2

Consider a formal commitment to sustain the partnership and the work ahead.

Sustainability

New York State Health Foundation Sustainability Toolkit

Suggests choosing 3-4 factors to sustain a project

APPENDIX A

SUSTAINABILITY FACTORS:
DEFINITIONS AND EXAMPLES

SUSTAINABILITY DEFINITION:

When new ways of working and improved outcomes become the norm.[1]

PERCEIVED VALUE – acknowledged value by those affected by the new ways of working and improved outcomes. Examples include project activities being considered potentially beneficial by clients, service providers, or community members.

MONITORING AND FEEDBACK – monitoring is conducted on a regular basis and feedback is shared in easy to understand formats. Examples include information-gathering calls to monitor the project, and feedback provided to key staff using easy-to-understand formats (e.g., graphs).

LEADERSHIP – the degree to which leaders (including decision-makers and champions) continue to be actively engaged beyond the implementation stage. Examples include ongoing attendance at meetings focused on the new ways of working and ongoing monitoring of outcomes.

STAFF – staff has the skills, confidence, and interest in continuing the new ways of working and improved outcomes. Examples include staff being able to use a new referral system capably or thinking that a new curriculum is more effective in achieving better outcomes.

SHARED MODELS – continued use of a shared model among those involved in the new ways of working. Examples include the Chronic Care Model, the 40 Developmental Assets, the 5As, or Plan-Do-Study-Act (PDSA).

ORGANIZATIONAL INFRASTRUCTURE – degree to which organizational operations support the new ways of working and improved outcomes. Examples include rewriting job descriptions to support the project activities and channeling resources to project activities through the organization's business plan.

ORGANIZATIONAL FIT – degree to which the new ways of working and improved outcomes match the organization's overall goal and operations. Examples include project activities becoming part of the organization's strategic plan.

COMMUNITY FIT – degree to which the new ways of working and improved outcomes match community interests, needs, and abilities. Examples include an expressed desire for new or improved services and outcomes.

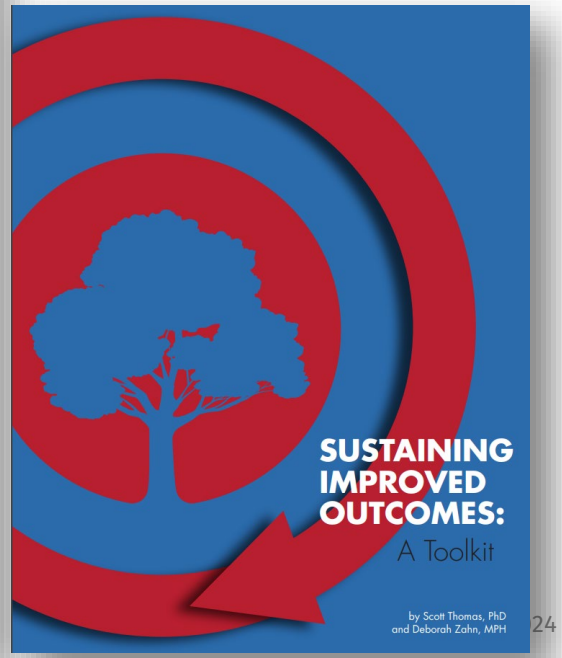
PARTNERS – involvement of partners who actively support new ways of working and improved outcomes. Examples include partners who continue to contribute staff or resources after the implementation phase.

SPREAD – expansion of new ways of working and improved outcomes to additional locations. Examples include expanding activities planned for one community agency or department to new agencies or departments.

FUNDING – funding beyond original project period. Examples include extensions of original grant funding or funding to expand project activities to additional populations or communities.

GOVERNMENT POLICIES – degree to which new ways of working and improved outcomes are supported by government policies. Examples include reimbursement for a new service or incorporating outcome measures into surveillance systems.

1 Sustainability: Model and Guide. National Health Service Institute for Innovation and Improvement. (2007). Note: When our work in sustainability began, the Sustainability: Model and Guide was publicly available online. Access is now limited to those working in the United Kingdom.



6. Demonstrate impact & tell the partnership story

Tell the story of your partnership and how it aims to make a difference in the communities you serve.

Consider the perspective of your audience – what are their potential ‘gains’ and their ‘pains’

Can tell the story before, during, and after the intervention!

CTSI
UNIVERSITY of ROCHESTER MEDICAL CENTER

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Clinical & Translational Science Institute / Education and Career / Health Equity Education

Health Equity Education Initiative

The Health Equity Education Initiative helps program leaders and educators of all student levels incorporate health equity into their curricula and build equitable clinical and research learning environments. As part of the URMC Equity and Anti-Racism Action Plan, the program provides resources, guidance, tools, and consistency for educators across all URMC departments and schools.

For Educators

Knowledge, Empathy & Equity Curriculum

This curriculum helps educators infuse health equity into existing curricula. Based on national health equity standards for health education from the American Association of Medical Colleges, Accreditation Council for Graduate Medical Education, and American Association of Colleges of Nurses, the framework and tools are applicable to medical, nursing, and graduate students, and more.

Access the KEE Curriculum

KEE Curriculum Assessment

The Knowledge, Empathy, and Equity (KEE) Curriculum self-assessment helps education program leaders evaluate their health equity curricula against national standards and competencies. If you are interested in doing a self-assessment, contact initiative director Theresa Green, PhD, MBA.

Contact Us

Learners at the University of Rochester are a vital part of the Rochester community with

Video Interviews with…

Linda Clark (Physician, Common Ground Health, Black Physicians Network)

Wade Norwood (CEO Common Ground Health, resident, pastor)

Telva Olivares (Physician, lead of Health Equity Task Force)

Michael Mendoza (Physician, Commissioner MCDPH)

Adrienne Morgan (VP Office of Equity and Inclusion, EARAP)

Andy Carey (Social Worker with URMC Street Outreach and REACH)

Mitch Gruber (Foodlink)

Shawn Nelms (Superintendent at EAST, Warner)

Jodi Cook (Teacher in science health pathway at EAST)

Malik Evans (Mayor Elect Rochester)

Luis Rosario-McCabe (School of Nursing, LGBTQ)

Angelica Perez (Ibero)

Seanelle Hawkins, EdD (President and CEO Urban League)

Kelly Mathews (National Center for Deaf Health Research)

Don’t forget to evaluate the success of your partnerships!

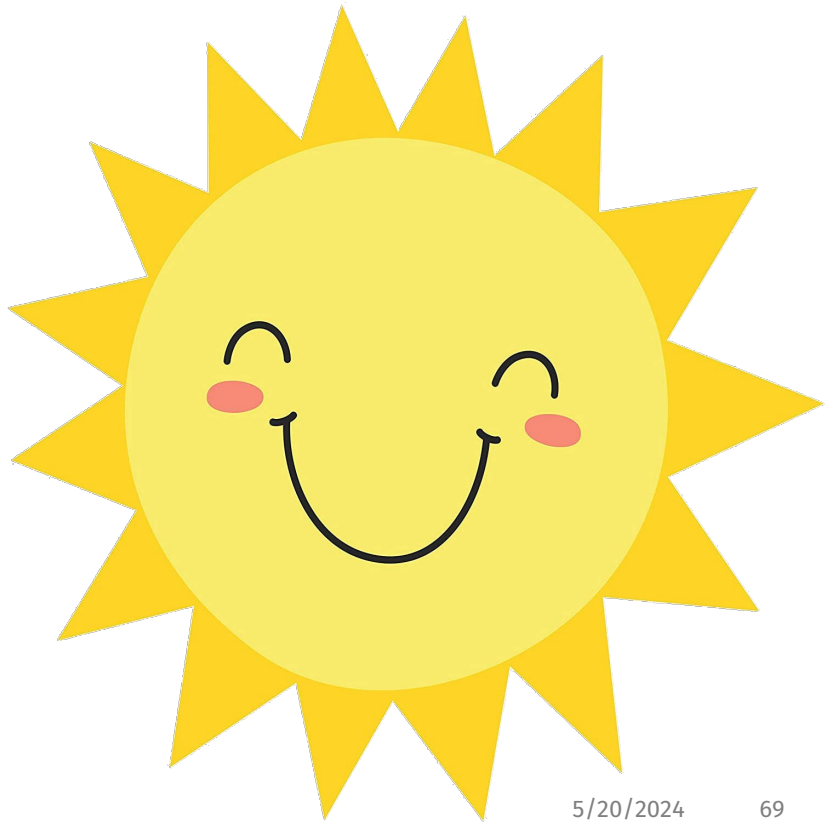
[Center for Healthcare Strategies: Partnership Assessment Tool for Health]

Keep the flame alive

The wise coalition leader will make the coalition a happy place to be. He or she will build in some fun - sometimes to relax, push all work to one side, and simply enjoy one another's company.

Find regular reasons to celebrate!

Members stay involved not just because of the work, but because they feel affirmed as full human beings because their human spirit is nourished.



thank you!

Theresa_Green@URMC.Rochester.edu

Additional Resources

Resources

1. New York State Prevention Agenda Dashboards
2. County Health Rankings and Roadmaps
3. AHA: Empowering Partnerships for Health Equity
4. ACHI Community Health Assessment Toolkit
5. AHA: A Practice-Based Framework for Working with Communities
6. Five Tools for Helping Turn Big Ideas into Action: an Integrator's Toolkit
7. Center for Healthcare Strategies: Partnership Assessment Tool for Health
8. Community Tool Box, Center for Community Health and Development, University of Kansas: Maintaining a Coalition

COMMUNITY HEALTH ASSESSMENT TOOLKIT

PREPARE Before You Begin	STEP 1 Map Development	STEP 2 Build Relationships	STEP 3 Develop Community Profile	STEP 4 Increase Equity With Data
STEP 5 Prioritize Needs and Assets	STEP 6 Document and Communicate Results	STEP 7 Plan Equity Strategy	STEP 8 Develop Action Plan	STEP 9 Evaluate Progress

Community Health Assessment Toolkit

Welcome to the American Hospital Association's Community Health Assessment Toolkit. As in earlier releases, this updated toolkit provides a nine-step guide for hospitals and health systems to collaborate with their communities and strategic partners to conduct a community health assessment (CHA) and meet community health needs assessment (CHNA) requirements.

Given the unequivocal call to accelerate health equity for all communities, this toolkit reflects the understanding that while CHNA reporting may be required only for nonprofit hospitals and health systems, the CHA process is one that all hospitals can undertake.

View CHA Resources

ACHI
AHA Community Health Improvement

Five Tools for Helping Networks Turn Big Ideas into Action: An Integrator's Toolkit

Big Ideas & Supporting Tools

This toolkit is organized around five big ideas, each with a supporting tool.

1

IDEA #1: Networks are strengthened when integrative activities are named, supported, and prioritized. Integrative activities are the governance, management, and administrative functions that enable population health networks to carry out tasks and strategies related to the network's shared population health goals.

- ***Tool #1: Integrative Activities Inventory*** – Assesses the degree to which integrative activities are in place within the network.

2

IDEA #2: Networks are strengthened when they regularly take stock of which integrative activities are in need of more attention to help them go further, faster.

- ***Tool #2: Aligning Integrative Activities with Network Strategic Plans*** – Aligns and prioritizes integrative activities with existing strategic plans of the networks, to accelerate network progress.

3

IDEA #3: Networks are strengthened when responsibility and accountability for integrative activities are shared among multiple network members, preventing one or a select few from shouldering the burden of responsibility.

- ***Tool #3: Distributed Accountability*** – Identifies opportunities to distribute accountability for integrative activities among a greater number of network partners.

4

IDEA #4: Networks are strengthened when the organizational representatives at the table are "present with purpose"– the organization's contribution of time, people-power, funding, and/or other resources is a deliberate part of the organization's own strategies.

- ***Tool #4: Being Present with Purpose*** – Supports partner organizations in clarifying their participation in the network, planning resources to be allocated to the network, and articulating how/where network participation aligns with organizational goals.

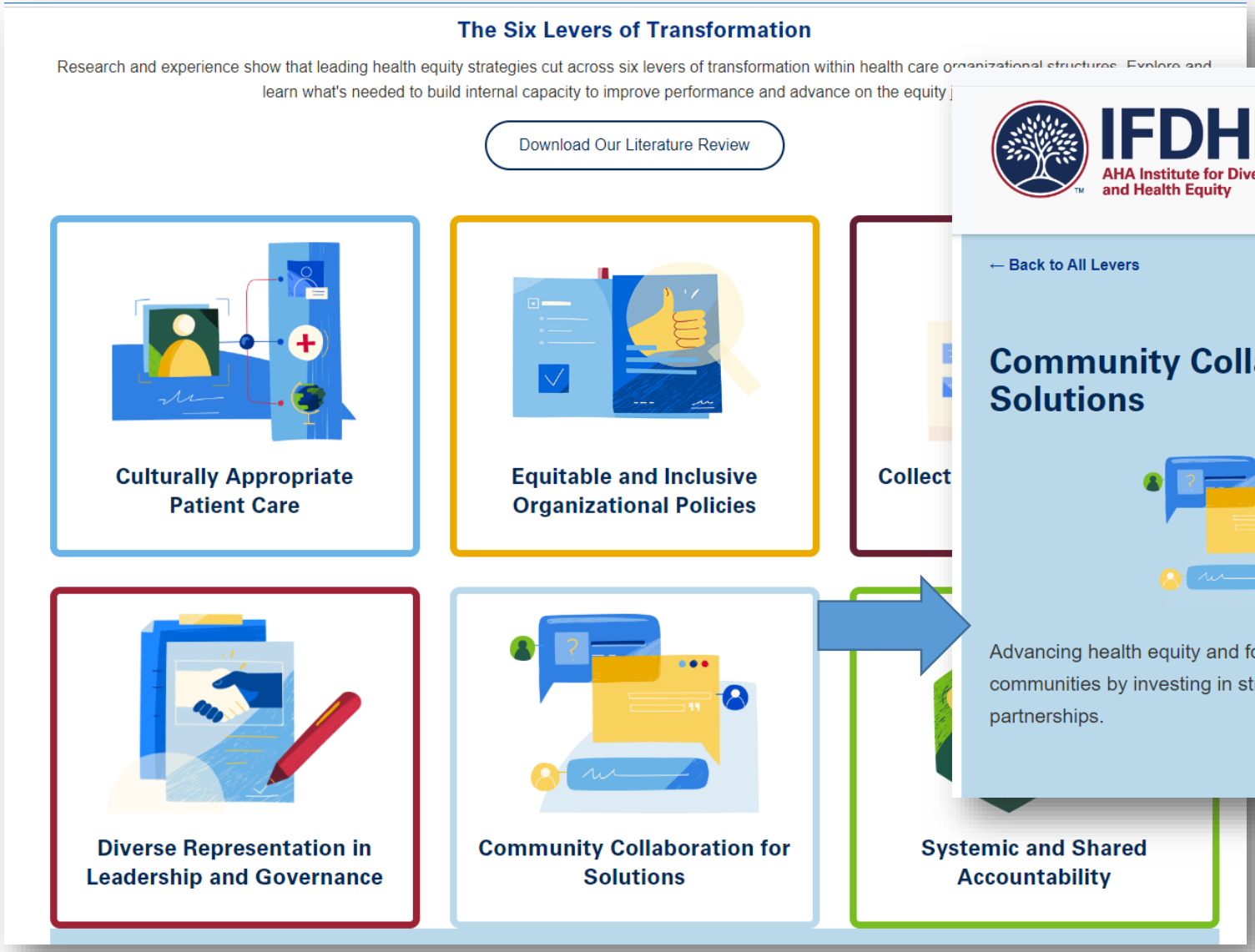
5

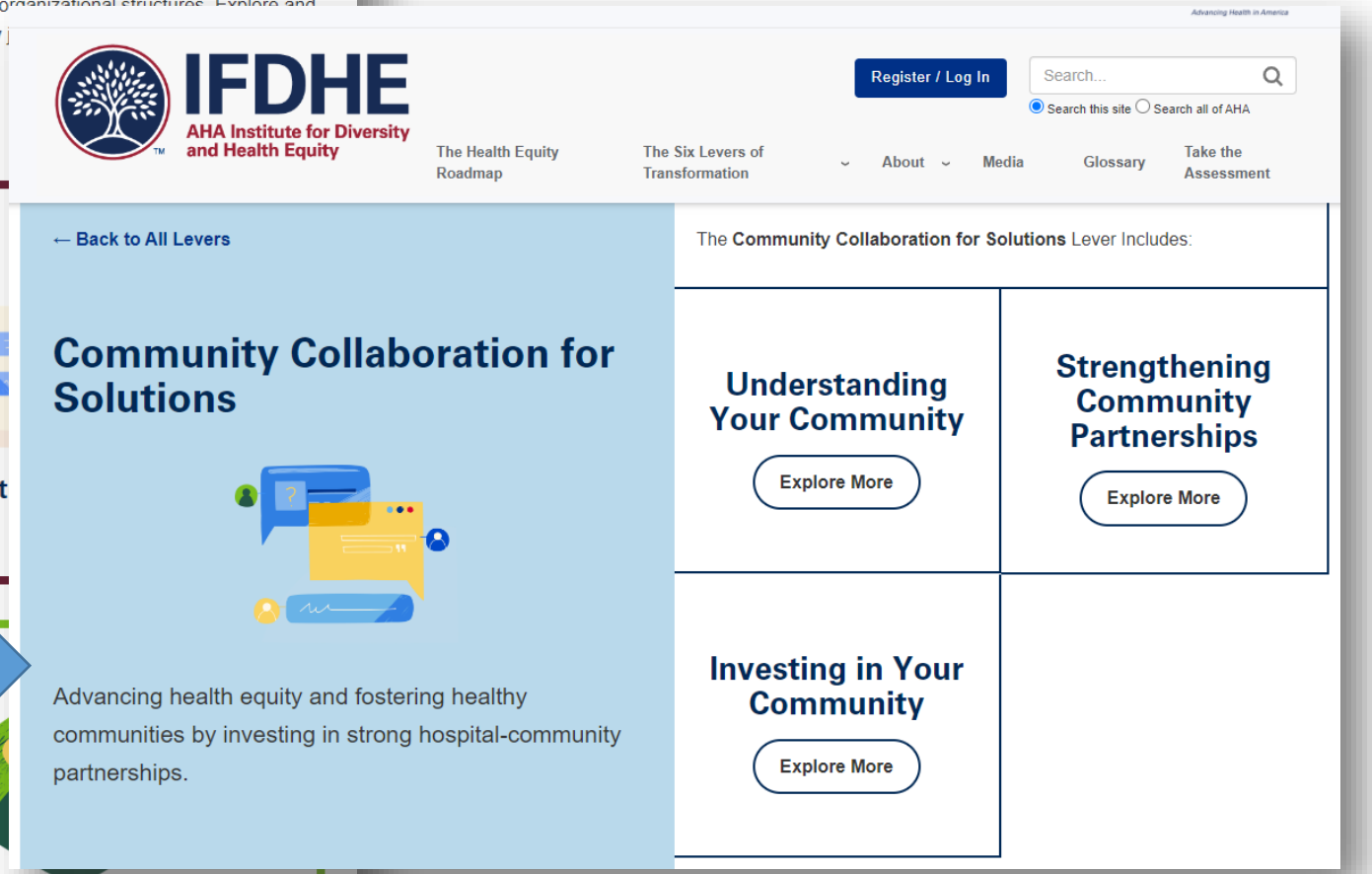
IDEA #5: Networks are strengthened when members share common values and agree about the importance of ensuring the network's actions reflect its values.

- ***Tool #5: Network Values*** – Assesses the degree to which guiding values and principles are shared among network members.

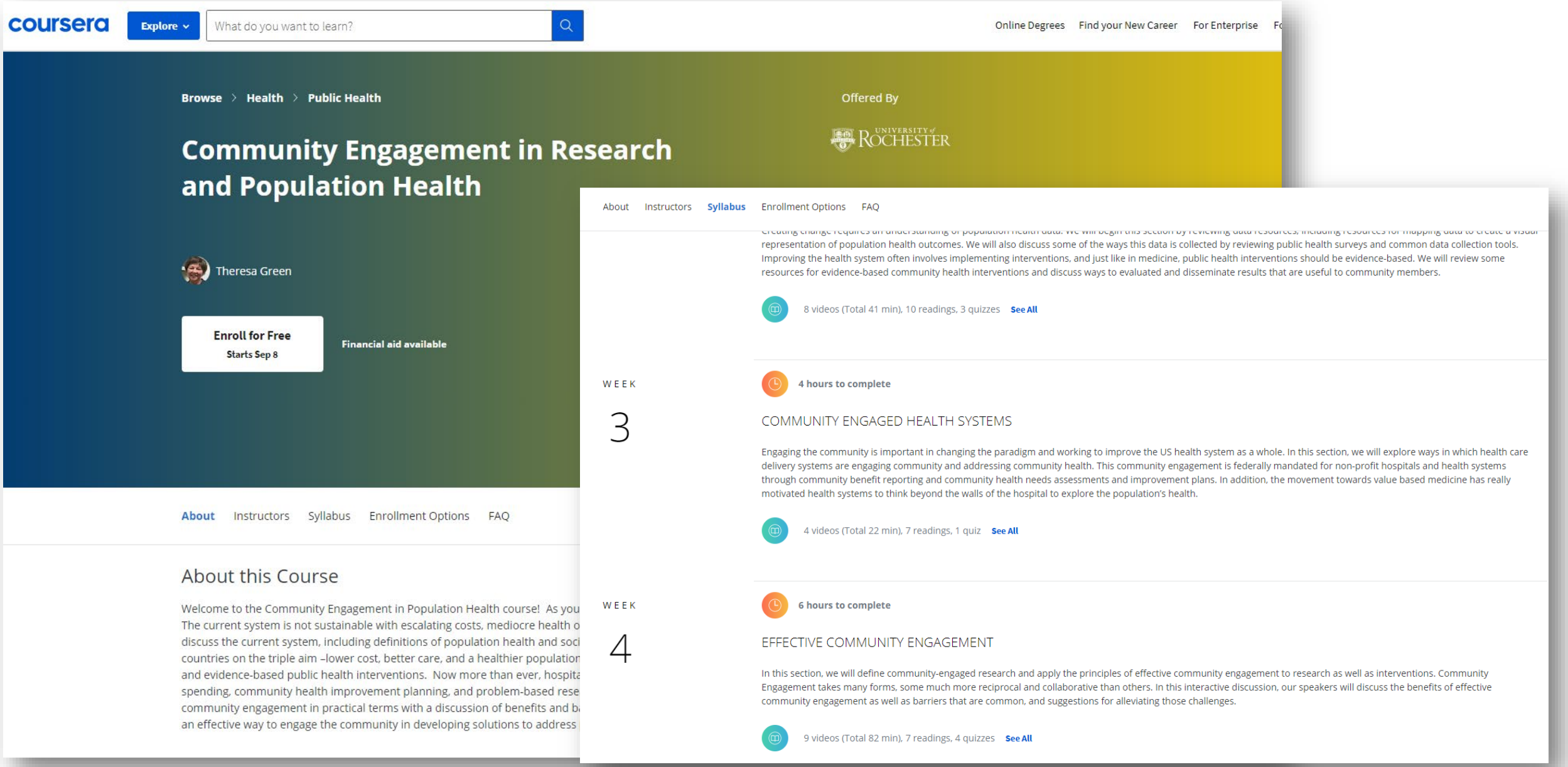
Five Tools for Helping Turn Big Ideas into Action: an Integrator's Toolkit

AHA Health Equity Roadmap: https://equity.aha.org/





Community Engagement in Research and Population Health



Upcoming session

Tuesday, May 28 | 11 a.m. to noon.

Patient and family engagement

Our final session covers best practices for engaging patients and families in their care.

This will be the final session of the spring series.

Register here.

ADVANCING HEALTHCARE
EXCELLENCE AND INCLUSION

Questions?

Morgan Black, MPA
mblack@hanys.org

AHEI Team
ahei@hanys.org

HANYS
Always There for Healthcare