Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies

Impact Stories

NATIONAL ACADEMY OF MEDICINE

The Walkability Project

How pivoting toward a community's goal to improve its built environment led to long-term change.

TIMEFRAME	2017
COMMUNITY	Urban, low-income
GEOGRAPHY	Roseville, California
FOCUS	Walkability
CORE PRINCPLES	Inclusive, Co-created, Culturally-centered
COMMUNITY ENGAGEMENT OUTCOMES	**Strengthened Partnerships + Alliances** Expanded Knowledge **Improved Health + Health Care Programs + Policies** **Thriving Communities**

PROJECT BACKGROUND

How can we expect communities to live healthy lives when their public spaces are unsafe? Funded by a $60,000 award from the Robert Wood Johnson Foundation, the Health Education Council (HEC) engaged the community of Roseville, California in an effort to improve the health of its residents. HEC is a nonprofit organization committed to promoting health and preventing chronic disease in underserved communities. The funded proposal was designed to address food insecurity—a well-documented need in the community supported by many data sources, including community health needs assessments from local hospitals, CalFresh Supplemental Nutrition Assistance Program (SNAP), and school lunch programs.

After receiving the award, HEC went back to community residents to confirm that the project was a community priority. "We asked, 'what's nearest and dearest to you when you think about health? What comes to mind?'" said Debra Oto-Kent, MPH, Founder and Executive Director of HEC. The resulting neighborhood input highlighted that food insecurity was not the highest priority. In fact, residents consistently raised having a safe and walkable neighborhood as a bigger need. Specifically, the neighborhood park was identified as not feeling like a safe, usable environment for families. Walkability to local stores was also called out, as there were no curb cuts for wheelchairs, shopping carts, and strollers. Based on community guidance, HEC pivoted and redesigned its strategy around what community members said they wanted.

Watch Debra Oto-Kent, HEC Founder and Executive Director, describe the Walkability Project and its sustained community impact.

KEY ENGAGEMENT ACTIVITIES

> *"We did kitchen table discussions, we met in people's backyards. We engaged with parents after school. We cast a very wide net when talking to people…and based on that input, we pivoted and changed our approach.*
>
> *Debra Oto-Kent*
> *HEC Founder and Executive Director*

To align the project with community priorities, HEC pursued a series of engagement strategies to incorporate community members into all aspects of the work.

Built a mechanism for broad community inclusion throughout the project. A five-member, cross-sector team and advisory committee of community-based organizations and residents were assembled to confirm project goals with the community. This was important because other neighborhoods in the city had neighborhood associations that could advocate for their needs; this community did not.

Engaged as many stakeholders as possible, and met them where they lived and worked. The advisory committee sought input from diverse stakeholders with everyday experience of the community. These included residents in core neighborhoods, neighborhood associations, city officials, hospitals, health and social service agencies, faith organizations, and law enforcement. To do so, the advisory committee held key informant interviews, backyard chats, after-school engagement with parents, and focus groups. Notably, they reached out to people who had not been involved and did not know who to turn to in order to make their voices heard.

Experienced the park firsthand. HEC engaged in a walking audit in which they toured the park to experience the setting and its issues for themselves, including broken benches and drug paraphernalia. These efforts brought home the specific ways in which safety was an issue and a barrier to use of the park and activities such as walking groups which could improve health.

PROJECT OUTCOMES

The partnership between HEC and the community created a stream of benefits:

Generated new programs and improved quality of life. HEC has since leveraged their original $60k award into additional forms of support that have collectively raised the life quality of the community. For examples, HEC applied for and received block grants to fix sidewalks; they partnered with the city and secured a $750k grant to fix a swimming pool; Kaiser Permanente awarded two improvement grants to build classrooms and an outdoor learning center in the park; the local electricity company prioritized the Roseville park in its program to upgrade streetlights to brighter LED bulbs; and the Parks and Recreations department started implementing new programs, including yoga and soccer, movie nights in the park, and the "Saturday in the Park" program where nonprofits set up tables and provided service information to local residents.

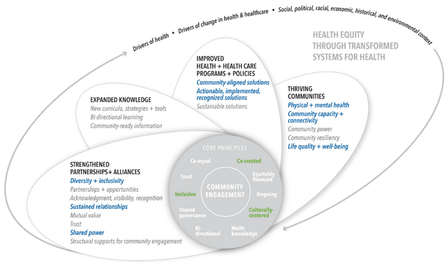
Created sustained infrastructure for ongoing community action. The advisory committee has continued to meet monthly. Furthermore, there are now three active neighborhood associations that meet regularly and share updates with the advisory committee. Most significantly, rapid changes to the built environment (lights, benches, classroom, etc.) were visible to residents, who could see results from their participation. This built "civic muscle" among residents who had previously felt disconnected and did not know who to talk to about local issues.

Built relationships with and within the neighborhoods. As a result of new and strengthening relationships, when COVID-19 emerged, community members were ready to address food insecurity issues. HEC partnered with the city, local contributors, and local restaurants that were severely impacted by closures to launch Family Meals Roseville. Residents and food service providers set up drive-up school programs and new food access points, delivering nearly 20,000 hot meals to neighborhood families.

Listen as community member and neighborhood association president Steve Parker describes the effects of park improvements.

ASSESSING COMMUNITY ENGAGEMENT OUTCOMES

Below, the Assessing Community Engagement Conceptual Model is mapped to the Impact Story. This mapping illustrates how CORE PRINCIPLES of engagement lead to impact across the four OUTCOME domains, and to specific measurable indices within those domains.



The Walkability Project began with CORE PRINCIPLES of: **inclusive** participation (talking to people who had not been previously engaged), **co-creation** (redesigning the project with community to reflect their priorities), and a **culturally-centered** approach (centering local culture when developing engagement processes and goals).

This approach generated STRENGTHENED PARTNERSHIPS + ALLIANCES, including **diversity + inclusivity** (reinvigorating neighborhood associations with previously unengaged community members); **sustained relationships** (neighborhood associations and the advisory committee continue to meet); and **shared power** (residents have heightened expectations and new structures for initiating other community improvement efforts).

Together, Roseville residents and the HEC IMPROVED HEALTH + HEALTH CARE PROGRAMS + POLICIES through **community-aligned solutions** that are **actionable, implemented, and recognized** (upgraded park lighting, pool revitalization, and the remodeled park classroom are visible signs of neighborhood improvement; the resulting yoga and soccer programs, movie night in the park, and the "Saturday in the Park" program are also tangible successes).

Today, the Walkability Project fosters THRIVING COMMUNITIES through improved **physical + mental health** (increased numbers of walking clubs and other outdoor group activities) and **community capacity + connectivity** (more community members have turned out to discuss new park-related projects, such as a potential affordable housing development and a new community center). **Life quality + well-being** have also been improved (a stronger presentation of residents in the streets and in the park, which in turn improves perceived social cohesion and safety).

How a community/researcher partnership advanced awareness of opioid use disorder and treatment infrastructure in rural Colorado.

TIMEFRAME	2016-2020
COMMUNITY	Rural
GEOGRAPHY	Eastern Colorado
FOCUS	Medication assisted treatment for opioid use disorder
CORE PRINCIPLES	Co-created, Co-Equal, Culturally-centered, Trust
COMMUNITY ENGAGEMENT OUTCOMES	**Strengthened Partnerships + Alliances** **Expanded Knowledge** **Improved Health + Health Care Programs + Policies** **Thriving Communities**

PROJECT BACKGROUND

Since its inception in 1997, the High Plains Research Network (HPRN) has built a robust geographic network comprising over 50 small physician practices, 16 hospitals, and community organizations in 16 rural and frontier counties in eastern Colorado. In 2015, network members approached the HPRN with an urgent need to address rising rates of opioid addiction. A significant challenge in the U.S. is the lack of medical providers who are certified to prescribe buprenorphine, a highly effective and FDA-approved medication, as part of medication assisted treatment (MAT) for opioid use disorder (OUD). In Colorado, few if any rural primary care practices had providers who could treat addiction or offer MAT. In response, the IT MATTTRs Colorado (Implementing Technology and Medication Assisted Treatment and Team Training in Rural Colorado) study was designed and funded by the Agency for Healthcare Research and Quality (AHRQ) in 2016. IT MATTTRs focused on: 1) training primary care providers to qualify for the required waiver to prescribe buprenorphine as part of MAT; 2) training primary care practice teams to deliver MAT; and 3) building community-level knowledge and awareness of MAT and combating the significant local stigma that prevented individuals from seeking treatment. Project goals were to sign up 40 clinics for team training and certify 10 providers to prescribe buprenorphine in the first two years of the program.

KEY ENGAGEMENT ACTIVITIES

> *"Pre-work is a misnomer. There is no pre-work. Community engagement IS the work."*
>
> *Jack Westfall, Founder of HPRN*

Invested in pre-project community relationships. Since 2003, Jack Westfall, MD, MPH, a family medicine doctor and founder of HPRN, had convened quarterly meetings with the Community Advisory Council (C.A.C.) comprising local farmers, ranchers, teachers, students, small business owners, and retirees. Together, they built a track record of academic-community partnerships and projects, beginning with colon cancer prevention in 2004 and followed by a series of initiatives that included diabetes and mental health—all driven by community priorities. Dr. Westfall highlights that this prior work was key to setting the stage for IT MATTTRs. "You can't go in and run a study like IT MATTTRs cold."

Supported participatory grant writing. Working with community members, HPRN spent six to nine months co-constructing the grant proposal, ensuring its goals aligned with community and provider priorities. Dr. Westfall notes: "We couldn't do it without the people in the network. And they really needed our support and expertise as well."

Developed multi-disciplinary, multi-sector translation teams. Once funded, the HPRN engaged community members from different geographic regions, including the San Luis Valley and its local community advisory group. Together they translated OUD treatment guidelines and messages from jargon-filled medical language into locally relevant concepts and terms. They used the Boot Camp Translation process, a communication participatory research method developed by HPRN for the explicit purpose of making complex medical terms and concepts easier and more relevant to local groups. The resulting concepts and terms were integrated into the next phase of work—translating national MAT guidelines into a training curriculum and ensuring that messages for the clinics were parallel to messages for the community. While MAT curriculum and materials were developed by an HPRN-convened group of specialists (including behavioral health, pharmacy, a physician assistant, and a primary care buprenorphine specialist), community perspectives were solicited at multiple points during the development process. "They would go through the curriculum with us and remind us: make sure there's some piece about how this relates to the patients who are coming from Limon and Sterling and Hugo and Yuma," recalls Dr. Westfall.

Leveraged a community-driven dissemination strategy. To build awareness and demand for MAT, the C.A.C.s worked with a local graphic designer to develop locally tailored community intervention materials. The HPRN C.A.C. designed the "Have you Met MAT" communication materials; the San Luis Valley C.A.C. developed its "MAT for OUD in the SLV" communication materials. Language and concepts from the Boot Camp Translation effort informed the content. An explicit design goal was to promote conversation about treatment and reduce the stigma of addiction. Local community members distributed the resulting posters, drink coasters, and other materials to local restaurants, bars, churches, community organizations, pharmacies, and schools. Community members also designed a movie trailer for local theaters to play in advance of movies. Public radio coverage and written summary of the MAT initiative by local station KUNC in 2019 further expanded program reach.

PROJECT OUTCOMES

IT MATTTRs produced impact on three levels:

Improved public health. The 24 counties in the study region registered an 87% increase in OUD treatment from 2014-2019, compared to a 65% increase in the rest of Colorado.

Grew the number of MAT prescribers across the region. Training reached 42 practices and 441 practice team members—98 clinicians, 207 clinical support staff, 107 administrative support staff, and 29 others. The number of certified MAT prescribers in the region increased from three to over 35 during the course of the study. Providers self-reported that their ability to deliver MAT improved significantly, according to a follow-up survey.

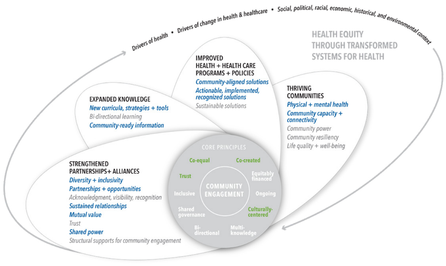
Created new awareness and ability in the community. A community survey was distributed throughout the study region before and after the distribution of community intervention materials. Survey results suggest materials successfully reached over half of respondents, which is significant given the geographic spread of the region and the constrained budget for producing community materials. A greater percentage of post-study respondents could identify local treatment sites for OUD resources in their community and reported greater awareness of MAT, primary care, behavioral health, and outpatient treatment resources in their community as compared to baseline.

The team also assembled a MATerials Resource Toolkit to assist provider practices in treating patients.

Listen as C.A.C. member Maret Felzien, MA, talks about why community engagement principles are good for everyone.

ASSESSING COMMUNITY ENGAGEMENT OUTCOMES

Below, the Assessing Community Engagement Conceptual Model is mapped to the Impact Story. This mapping illustrates how CORE PRINCIPLES of engagement lead to impact across the four OUTCOME domains, and to specific measurable indices within those domains.



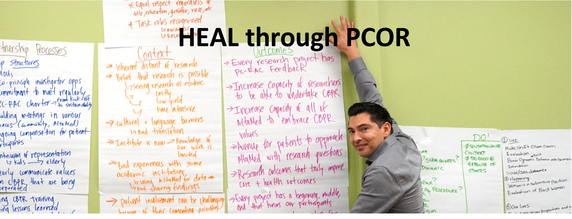
The IT MATTTRs partnership and project began with CORE PRINCIPLES of **trust** (built through years of collaborative work), **co-created** (achieved through a jointly defined process), **co-equal** partners (evidenced by shared decision-making), and a **culturally-centered** focus (built in Boot Camp Translation).

This approach generated STRENGTHENED PARTNERSHIPS + ALLIANCES, including **diversity + inclusivity** (incorporating members from different regions, including individuals with lived experience); **partnerships + opportunities, sustained relationships**, and **shared power** (C.A.C. members continue to identify topics for future contribution and self-identify as willing to help); and **mutual value** (C.A.C. members can see and experience results of their efforts in the community).

The project EXPANDED KNOWLEDGE in the form of **new curricula, strategies + tools** and **community-ready information** (community-tailored MAT provider training and promotional materials).

Collaborating with community members IMPROVED HEALTH + HEALTH CARE PROGRAMS + POLICIES with **community-aligned solutions** (both improved provision and patient uptake of MAT) and **actionable, implemented, recognized solutions** (other regions in Colorado are now using the IT MATTTRs method to address their local OUD needs).

Ultimately, IT MATTTRs contributed to THRIVING COMMUNITIES through improved **physical + mental health** (significant increases in patients per year with a prescription for buprenorphine from a local provider) and **community capacity + connectivity** (the new capacity among rural practices to treat OUD is all the more important given their central role in rural communities, and community members continue to participate in the C.A.C.s today).



HEAL through PCOR

How a health system in Los Angeles assembled the infrastructure and processes to incorporate communities in research, public health efforts, and health service design.

TIMEFRAME	2019-2021
COMMUNITY	LatinX
GEOGRAPHY	Los Angeles, California
FOCUS	Strengthening patient and community engagement within an FQHC
CORE PRINCIPLES	Co-created, Multi-knowledge, Bi-directional
COMMUNITY ENGAGEMENT OUTCOMES	**Strengthened Partnerships + Alliances** **Expanded Knowledge** Improved Health + Health Care Programs + Policies **Thriving Communities**

PROJECT BACKGROUND

Many organizations want to grow and systematize their capacity for community engagement but may not know how to get started. AltaMed, one of the largest Federally Qualified Health Centers (FQHCs) serving Southern California, offers lessons and encouragement for how to build a coordinated, system-wide capacity for community engagement.

AltaMed has a long history of engaging the LatinX community in Los Angeles. It is also one of the few FQHCs in the U.S. with an independent research department dedicated to addressing health disparities. As a result, AltaMed receives frequent requests to partner with other universities and community organizations. But until recently, it had no streamlined process for doing so. This resulted in mixed value for AltaMed and its community members. "We realized that patient-centered research can't really exist in a silo at AltaMed, and that to be effective these efforts should be interconnected," recalls Dr. Melissa Chinchilla, PhD, MCP, MS, a research scientist who ultimately led the work at AltaMed. Recognizing the need to create a broader organizational approach, in 2019 AltaMed applied for and received funding from the Patient-Centered Outcomes Research Institute (PCORI). The resulting *Health Equity and Access for Latinos through Patient-Centered Outcomes Research Capacity-Building* (HEAL through PCOR) engagement award provided a mechanism to reassess all of AltaMed's current structures and processes for engaging patients and communities in health equity research and advocacy.

KEY ENGAGEMENT ACTIVITIES

The HEAL through PCOR vision was to systematize community engagement throughout AltaMed and its key activities: policy advocacy, research, health services, community health programs, and medical education. To get started, Dr. Chinchilla and her team:

Built a coalition of internal and external stakeholders. Over 30 community leaders, patients, medical providers, academic partners, and medical students were convened. To incorporate community perspectives, leadership reached out to people who had previously participated in AltaMed research or community engagement efforts. Those stakeholders were in turn encouraged to invite colleagues whose interests aligned with project goals. Many AltaMed employees also grew up or lived in the AltaMed service area. Collectively, these stakeholders were able to bring important resources to the table, including access to their networks and insights about how to successfully engage patients and community members. Together, they reviewed current AltaMed engagement processes and systems in monthly and quarterly working sessions.

HEAL through PCOR investigator Dr. Melissa Chinchilla offers advice to other health systems seeking to build their organizational capacity for community engagement.

Applied Community-Based Participatory Research (CBPR methods. The team brought in outside experts to introduce CBPR principles and practices to all stakeholders (including medical professionals). Throughout the project, the team used CBPR principles and tools, such as partnership surveys and interactive activities, to stimulate reflection and equal contribution.

Worked cooperatively and adaptively. The team moved online in response to COVID-19, compensating for the lack of in-person connection with an increase in the number of meetings. They then used a snowball approach to expand participation: local nonprofit organizations joined various sessions, and additional community members were surveyed or joined interviews and focus groups. Collectively, this expanded group reviewed all the processes and structures used at AltaMed to engage community members.

> *"Transparency and accountability to your organization are key. A lot of times this work doesn't happen overnight. It's a journey. So it's important to help people see that progress is being made, or they will get frustrated."*
>
> *Dr. Melissa Chinchilla, lead of HEAL through PCOR*

PROJECT OUTCOMES

HEAL through PCOR laid the groundwork for AltaMed to infuse patient and community engagement into its programs, including research. Specific outcomes include:

Built a multi-year, system-wide plan for community engagement. The team drafted a five-year plan for building system-wide community engagement capacity. *Near-term programs* would embed community members into current efforts: community-engaged advocacy (e.g., voter drives), community-embedded research studies, trainings for medical professionals on how to engage community members, and one-off health services efforts such as vaccine drives. *Mid-term programs* would expand to civic engagement campaigns around the social determinants of health, engaging community members as co-investigators on grants, and co-developing medical educational curricula and new health services with community members. *The long-term programs* centered on a new Patient and Community Advisory Council to channel community priorities into all of AltaMed's policy advocacy, research, health services, community health programs, and medical education activities.

Increased cross-departmental coordination for patient and community engagement. HEAL through PCOR brought together people and departments that typically did not talk to each other. This helped link civic engagement, research, and policy efforts across the organization. For example, the Strategic Analytics department maintained a list of community members who, when surveyed for their clinic experience, self-identified as wanting to join advocacy and research efforts—but Strategic Analytics had no way to engage them. Similarly, the Research department accrued patient stories of clinic and care experiences of potential relevance to Strategic Analytics but did not know the other department could use these stories. The two departments started meeting bi-monthly to share information and jump-start community member referrals.

Formulated new processes, guidelines, and tools to foster integration of community engagement. The stakeholder group drafted *new guidelines* for community- and patient-centered practices in research, research dissemination, and partnership identification. For example, "one of the things we realized is that these stakeholders had such great ideas for appropriate ways to speak to patients and community members, for using accessible language, for making sure we thank them for their time," notes Dr. Chinchilla. These guidelines are now presented to all new AltaMed research partners with the expectation that they will align their behavior to the standards. The coalition also recognized that AltaMed needed to adopt standardized language—such as social determinants of health categories—to describe, track, and share community needs across departments. The group helped revise the *partnership application* because "oftentimes we had negative experiences with external researchers that helicoptered in and then left and didn't provide any information about the activities or research findings," said Dr Chinchilla. The new application asks for a dissemination plan back to AltaMed.

Launched a seven-week community research training academy. Recognizing that community members benefit from training before participating in health services research, the AltaMed Institute for Health Equity applied for and received a second PCORI award. The PARTNER SELA program trains members of the Southeastern Los Angeles (SELA) community to engage in patient-centered outcomes research. The program generated significant interest, and a cohort of 19 community members participated in the program's first run. Program graduates reported enhanced confidence in their ability to collaborate on research projects as a community researcher. At five months post-training, all participants remained active in community research projects—for example, leading focus groups with SELA youth to understand their priorities and concerns about mental health. These efforts were central to AltaMed's securing funding to launch a youth-led mental health project in Orange County.

ASSESSING COMMUNITY ENGAGEMENT OUTCOMES

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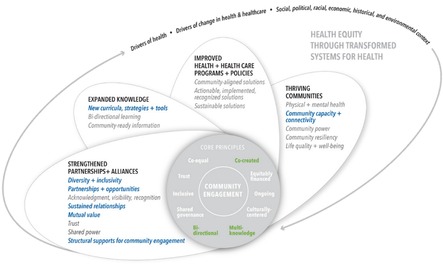

The HEAL through PCOR initiative used CORE PRINCIPLES of **multi-knowledge** (assembling a broad range of perspectives both internal and external to AltaMed), **co-created** (continuous collaborative work), and **bi-directional learning** (mutual discovery within and between external and internal stakeholders).

This approach generated STRENGTHENED PARTNERSHIPS + ALLIANCES, including **diversity + inclusivity** (incorporating residents of disempowered communities served by the FQHC); **partnerships + opportunities** and **sustained relationships** (ongoing engagement with community members through dedicated activities); **mutual value** (training community members in CBPR methodologies); and **structural supports for community engagement** (development of system-wide tools, processes, and practices for community engagement and establishment of the EMPOWER-ACT Committee, where AltaMed stakeholders continue to partner in patient and community engagement efforts across various programs).

The project EXPANDED KNOWLEDGE in the form of **new curricula, strategies + tools** (through the new community training program, PARTNER SELA, and new practice guidelines for effectively communicating with community members).

HEAL through PCOR contributed to THRIVING COMMUNITIES through **community capacity + connectivity** (creating a network of participants that can inform advocacy programs and research efforts going forward).

Establishing a Faith-Based Organizational Network

How networking Black ministers created new regional capacity for improving community health.

TIMEFRAME	2019-2021
COMMUNITY	Rural, Black faith-based communities
GEOGRAPHY	North Carolina
FOCUS	Promoting health equity in North Carolina communities
CORE PRINCIPLES	Culturally-centered, Co-created, Inclusive
COMMUNITY ENGAGEMENT OUTCOMES	**Strengthened Partnerships + Alliances** **Expanded Knowledge** **Improved Health + Health Care Programs + Policies** **Thriving Communities**

PROJECT BACKGROUND

It is increasingly clear that building relationships and engagement capacity with communities *before* conducting research is essential for health improvement initiatives. This practice-to-research—as opposed to the traditional research-to-practice—framework for engaging communities was embraced by Dr. Lori Carter-Edwards, PhD, MPH, then Associate Professor at the UNC Gillings School of Global Public Health, in her work. In 2014, Dr. Carter-Edwards, prior to securing any research funding, launched a series of meetings with North Carolina pastoral leaders and local health department staff with a twofold goal: learn about health-related priorities within their faith-based organizations (FBOs), and brainstorm what a network of faith-based leaders might accomplish. Together they conceptualized the Faith-Based Organization Network (FBON), a regional network of Black ministries that would function as cross-county infrastructure for connecting health efforts to local communities through churches. A specific goal was to establish collaborations that could more effectively address the social determinants of health in North Carolina's rural counties, where over 40% of its population lives.

FBON was launched in 2018 with a regional workshop for FBOs that focused on leadership capacity-building. It was conducted in partnership with the North Carolina Institute for Public Health, the Area L Area Health Education Center (AHEC), and interested FBOs in the AHEC's five-county area.

> "
>
> *As a researcher, it was understanding that the partnership itself is equally important as the outcome of the work. Therefore, the amount of time and energy that you put into it should be the same as the amount of time you put into the work itself.*
>
> *Dr. Lori Carter-Edwards, co-developer of FBON*

KEY ENGAGEMENT ACTIVITIES

From conceptualization to funding to launch, FBON engagement activities spanned the Eastern North Carolina region and several years. Activities include:

Conducted a series of exploratory meetings. In her 2014 meetings, Dr. Carter-Edwards worked with eight pastoral leaders from three regions of the state (each representing different Black faith-based networks), three to four community health staff from a health department, and a community-engaged researcher. The pastors constructed three priorities for FBON: first, identify data and success measures that could inform how they provided and improved health programs in their churches; second, develop network-wide competency in resource sharing and information dissemination; and third, strengthen the network's capacity by inventorying each member's unique role in their communities. In 2018, when a grant opportunity emerged, Dr. Carter-Edwards translated the group's work into a funding proposal. The grant was awarded in 2018.

Built a pastoral steering committee. A full year before FBON activation, Dr. Carter-Edwards assembled a five-member pastoral steering committee to flesh out priorities and develop a mission statement for the FBON. As FBON kicked off, the steering committee continued to be informed and engaged; one member joined the FBON workshop.

Activated the FBON network with a regional workshop. Each FBO sent a three-person team: a pastor or assistant pastor, a health minister or designated leader, and a food or culinary minister or designated leader. A total of 17 teams comprising 51 participants attended from four counties, all from predominantly Black faith-based communities.

Developed workshop activities to promote self-determinism and FBO capacity-building at three levels: 1) at the FBO level to identify health wishes, assets, and needs; 2) at the community level to identify county-level health priorities and resources; and 3) at the leadership role level to discuss the assets, needs, and action steps of each person's role (pastors, health ministers, and food/culinary leaders). To promote action back in the community, FBON participants were trained in a system-mapping exercise that helped them identify their local health priorities, expand their thinking about how to address those priorities, and identify what was needed to implement potential solutions. Teams then drafted a 60-day action plan for the priority of their choice and received a $300 start-up fund to promote implementation.

Provided community communication tools. FBON participants were given a newsletter template and encouraged to share their health promotion work with their community, local officials, and other FBON members.

Conducted follow-up assessment and support. Each three-member FBO team engaged in an hour-long structured interview to assess progress and measure post-workshop networking. Additionally, all 17 FBOs attended a joint meeting held 60 days after the workshop.

0:53

Listen as Dr. Lori Carter-Edwards advocates for a simple change in practice among researchers when partnering with community members.

2:20

Listen to Pastor James Gailliard describe how Dr. Carter-Edward's community-centered research approach created sustained value for his ministry.

PROJECT OUTCOMES

FBON jump-started action at multiple levels:

Expanded ministry priorities to include community health. At 60 days post-workshop, over 90% of FBOs reported successfully initiating or completing their goals. Projects included establishing a walking track around a church, inspiring walking challenges within and between FBOs, establishing coupon clubs and recipe sharing, initiating food giveaways, and installing vegetable garden beds. Pastor James Gailliard, an FBON member and continuing collaborator with Dr. Carter-Edwards, highlights the growth in his ministry's capacity to address the health of his community: "Out of FBON we got this broader and even deeper community organization and framework. Our scope has expanded from health to housing, education, criminal justice reform, employment. It has broadened so that we literally cover every aspect of people's lives. We have become flexible and fluid as an organization so that we can respond to a current crisis. Or if we don't have a current crisis, we can proactively begin to address social determinants of health or social determinants around education." He posits that FBON also encouraged the capacity-building of churches by "forcing them to take a look at health as a valid center of their ministry and to develop a group of lay people who could function as community engagement people. It forced churches to say, 'we probably need to add this to who we are.'"

Created professional visibility for participants. Many participants reported increased professional visibility: Five FBO leaders generated newsletters to communicate activities back to their membership, community, and local officials about their health promotion work. Several FBO leaders received invitations to present the framework at local and national meetings. When the COVID-19 pandemic occurred, all 17 FBOs were offered COVID-19 education webinars to help them provide leadership to their communities.

Built sustained partnerships for continued action. Follow-up interviews indicated increased connectivity between FBOs. One FBO connected with all participating FBOs; three made connections with six others across the five-county region. Notably, FBO pastors used the FBON governance structure to create a second, more comprehensive network: a 110+ member Eastern North Carolina Ministerial Alliance that extends across all five counties.

FBON also promoted sustained partnerships between faith-based leaders and researchers. Dr. Carter-Edwards notes that "taking this practice-to-research approach led us beyond what we had anticipated the relationship to be. We've written multiple grants together. We've received funding for COVID-related projects. [FBON member] Word Tabernacle Church has been able to write its own grants based on the research that we've done together. The initial FBON effort has served as a springboard for other researchers, who can now work with the network."

ASSESSING COMMUNITY ENGAGEMENT OUTCOMES

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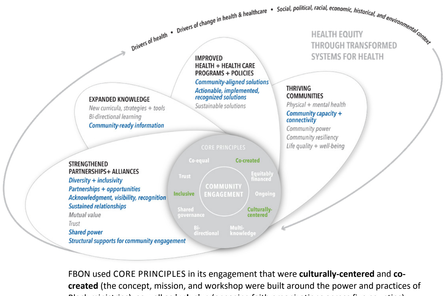


FBON used CORE PRINCIPLES in its engagement that were **culturally-centered** and **co-created** (the concept, mission, and workshop were built around the power and practices of Black ministries), as well as **inclusive** (engaging faith organizations across five counties).

Engagement activities resulted in STRENGTHENED PARTNERSHIPS + ALLIANCES, including **diversity + inclusivity** (17 FBOs from five counties participated, many of which had not been engaged in this type of capacity-building before), **partnerships + opportunities** (numerous connections between FBOs and an invitation to co-lead a grant), and **acknowledgment, visibility, recognition** (invitations to present locally and statewide). Members reported **sustained relationships, shared power,** and **structural supports for community engagement** (FBO leaders forming the Eastern North Carolina Ministerial Alliance).

Working collectively, faith-based leaders EXPANDED KNOWLEDGE in their communities by using **community-ready information** (at least five FBOs chose to disseminate their health-related efforts back to community and local audiences via newsletter).

Ministry-based partnerships led to IMPROVED HEALTH + HEALTH CARE PROGRAMS AND POLICIES, including **community-aligned solutions** and **actionable, implemented, recognized solutions** (all 17 FBOs meeting some part of their 60-day action plan, including completion of, or plans to move forward with, a health promotion project within or between FBOs).

Participating FBOs are succeeding in promoting THRIVING COMMUNITIES through improved **community capacity + connectivity** (adoption of health as a focus of ministry efforts, as well as the expanded mission of some ministries to address food, housing, education, criminal justice reform, and employment).

Building Native Wellness Networks

How Native communities are reviving their cultural wisdom to generate health solutions that work for them.

TIMEFRAME	2007-present
COMMUNITY	Indigenous peoples
GEOGRAPHY	American Southwest
FOCUS	Tribal health
CORE PRINCIPLES	Culturally-centered, Co-equal, Co-created, Multi-knowledge, Ongoing
COMMUNITY ENGAGEMENT OUTCOMES	**Strengthened Partnerships + Alliances** **Expanded Knowledge** **Improved Health + Health Care Programs + Policies** **Thriving Communities**

PROJECT BACKGROUND

Native communities across the United States experience the most health inequities compared to their non-Native counterparts. Many of the issues are preventable diseases, such as diabetes, obesity, and substance abuse, and can be improved through community and lifestyle approaches. Recognizing that health promotion strategies used in non-Native settings were not getting uptake or needed results in tribal communities, the Healthy Native Communities Partnership (HNCP), a national nonprofit in collaboration with the Indian Health Service, launched the Native Wellness Network program.

Since 2009, this program has convened cross-tribe coalitions in regional workshops to address health issues that all tribes share but may not be addressing together. Marita Jones, MPH, Executive Director of HNCP, underscores that the program goal is to reconnect Native communities to their own local strengths and cultural wisdom, as well as to strengthen ties between tribes to promote cross-tribe support, learning, and sharing of resources. "We really believe in the wisdom of the people, and our vision is for healthy and strong Indigenous communities," she notes. The program proceeds from two beliefs: cultural knowledge is protective and forms the foundation of successful health programs and interventions, and building the leadership skills and capacities of those most affected by health issues is the best catalyst for sustainable, positive community change.

HNCP hosts three to four workshops a year, depending on funding and interest from tribal communities. Out-of-state workshops are supported through grants or sponsorship from partners, such as the Indian Health Service and Tribal Health organizations, while local sponsors support New Mexico-based workshops. Broadly speaking, HNCP defines a "network" as the group of people, typically living in the same locale or region, who participate in recurring gatherings. A smaller number of its networks are national, bound together by shared topics.

Watch Marita Jones, HNCP Executive Director, describe how Native Wellness Networks promote tribal health, capacity building, and connectivity through cultural knowledge.

KEY ENGAGEMENT ACTIVITIES

> *"What's worked for us is letting people know that we are based in culture and tradition. People are hungry for it. What does it mean in America today to live as a Native person, to value the culture that we have, the language that we have, the traditions that we have?*
>
> *Marita Jones, Executive Director, Healthy Native Communities Partnership*

Native Wellness Network gatherings are two-day workshops called "Creating Community Circles for Change." These workshops serve two purposes: 1) continued support and extension of networks that have been built over prior gatherings, and 2) intensive consultation and coaching for participants. For each gathering, HNCP undertakes the following steps:

Selects a topic of mutual interest to tribes. For each event, HNCP collaborates with local community partners to identify health and wellness topics of mutual interest. This shared approach to agenda-building creates opportunities to discuss issues, such as suicide, that can be stigmatizing if there is no awareness that other tribal communities are struggling with these issues as well. Past Circles have addressed healthy weight; healthy kids; support for new families; promotion of healthy relationships to reduce family violence; breastfeeding; and re-connection to tradition, culture, and language. Circles can also incorporate environmental or transportation issues, as those factors affect wellness on many reservations. The process of identifying topics and co-constructing an agenda can take between one and six months.

Partners with a local host to help build coalitions for each Circle. Network gatherings are designed to widen the circle of community participants from each tribe. "The idea of coalition and coalition-building really came to the forefront to counteract STP, or 'the Same Two People' that always step forward," says Ms. Jones. Today, workshop planning starts by identifying an individual with broad knowledge of regional Native communities and their leaders. These "Network Weavers" identify a host for the workshop and collaborate with the host to recruit and build coalitions for each Circle. Local hosts are key to turnout, says Ms. Jones, because "people already have somebody that they know and trust." Local hosts also know where people live and work and can identify locations that are convenient.

Extends invitations to multiple tribal communities. Each Circle invites members from multiple communities and encourages participants to bring local partners so as to expand the number of people who can help with implementation. Network events are capped at 50 people for funding reasons. "It's important that the invitation feels personal," says Ms. Jones. "It builds that sense that you're needed, that you're important. And it builds a sense of reciprocity that you should help."

Travels to the community, rather than asks the community to come to them. Many reservations, such as New Mexico's Navajo reservation, host multiple tribes or Pueblos that are located near one another. As a result, workshops are typically held close to or on a reservation, and all surrounding communities are invited. Key locations such as Albuquerque can provide convenient access that maximizes participation from different tribal communities.

Designs engagement using Indigenous culture-centered models. Workshop activities are built around the Medicine Wheel—a centuries-old symbol used by many Native tribes in health and healing. The four directions of the Medicine Wheel represent all dimensions of wellness: physical, spiritual, mental, and social health.

Employs participatory methods throughout the workshop. Sessions are designed to promote tribal agency and voice, and to uncover the wisdom and resilience that has resided in their communities for centuries. Workshops start with a "focus question" to put the group in dialogue with each other around the workshop topic. Ms. Jones explains: "It's not a health education presentation about diabetes or rheumatoid arthritis, because most of the time people already know that. We start with more of a broad question: 'If you could make any changes in your community, what would that be and how could we do it together?'" Focus questions are followed by participatory methods, such as World Café (called "Rez Café"), open space technology, and theme clustering to promote interaction and active listening. Exposure to these tools and methods also teaches participants how they might engage their own communities in building new community-effective prevention and wellness strategies.

Promotes continuity over time. Participants grow more comfortable, build capacity, exchange updates about projects, and seek advice. Because most participants attend each year, "it really feels like a family reunion," says Ms. Jones.

PROJECT OUTCOMES

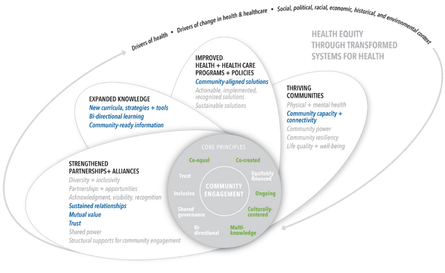
Network membership has taken time to build, due to lack of trust and lack of perceived agency to lead change. However, HNCP has seen less turnover in coalition members and participants, leading to greater trust and connection. Outcomes vary by network but, for example, the 250-member New Mexico Native Wellness Network has been thriving since 2012 and has:

- established a statewide support network,
- created local and regional partnerships,
- developed patterns of trust and reciprocity among community organizations,
- opened channels of communication between Native community groups that had been previously isolated from one another, and
- created links within the network between community groups based mostly on geographic proximity and increased their ability to assist each other with ongoing wellness work.

Using surveys and interviews with participants, Network Weavers, and the HNCP team, evaluation of the New Mexico network suggests: 1) improved leadership skills and effectiveness of local community members; 2) improved functioning of local Native community coalitions and increased connections and collective actions; and 3) improved capacity of community coalitions to track and evaluate processes and outcomes.

ASSESSING COMMUNITY ENGAGEMENT OUTCOMES

Below, the Assessing Community Engagement Conceptual Model is mapped to the Impact Story. This mapping illustrates how CORE PRINCIPLES of engagement lead to impact across the four OUTCOME domains, and to specific measurable indices within those domains.



Native Wellness Networks leverage CORE PRINCIPLES of **multi-knowledge** (convening cross-tribe coalitions) and **culturally-centered** engagement (approaches and materials embed the Medicine Wheel and other Native constructs and traditions). Processes are **co-equal** (all Circles employ community-based participatory methods that promote active listening and equal participation); **co-created** (agendas are devised with host organizations); and **ongoing** (networks are supported and nurtured over time).

Workshops STRENGTHENED PARTNERSHIPS + ALLIANCES between and within tribal communities by generating **sustained relationships** (workshops are drawing return members and members coming from farther away; within tribes, coalition members continue to work together on health programs). **Mutual value** and **trust** are also outcomes of HNCP workshops (as reported via participant surveys over time).

EXPANDED KNOWLEDGE, an explicit goal of the HNCP, is achieved with **bi-directional learning** (workshops promote knowledge exchange between tribes); **new curricula, strategies + tools** (workshop curricula and tools have been iteratively refined with participants over 15 years); and **community-ready information** (participants leave with actionable insights and strategies to use in their communities).

Workshops have led to IMPROVED HEALTH + HEALTH CARE PROGRAMS AND POLICIES with **community-aligned solutions** (new programs have been launched on many reservations, including the impactful Zuni Breastfeeding Coalition).

Efforts have generated THRIVING COMMUNITIES by expanding **community capacity + connectivity** (New Mexico coalition members reported increased connections with other organizations and initiatives in their communities).

Act NOW Against Meth

How a campaign to influence policy activated disenfranchised citizens, built community power, and drove policy change in Los Angeles County.

TIMEFRAME	2005-present
COMMUNITY	LatinX, LGBTQ, and other underserved communities
GEOGRAPHY	Los Angeles, CA
FOCUS	Methamphetamines, HIV
CORE PRINCIPLES	Co-equal, Co-created, Ongoing, Culturally-centered, Inclusive
COMMUNITY ENGAGEMENT OUTCOMES	**Strengthened Partnerships + Alliances** Expanded Knowledge **Improved Health + Health Care Programs + Policies** **Thriving Communities**

PROJECT BACKGROUND

In 2005, frustrated by rising HIV infections among LatinX gay men in Los Angeles County linked to the use of methamphetamines (meth), the Act Now Against Meth (ANAM) coalition was formed. ANAM was founded by Richard Zaldivar, Founder and Executive Director of The Wall Las Memorias Project (TWLMP), with strong support from the Asian Pacific AIDS Intervention Team. "Back then, the Los Angeles County Office of AIDS Programs found that out of every five cases of HIV, three could be attributed to meth," Zaldivar said. The ANAM coalition was broad and intentionally grassroots, comprising local businesses, a local hospital, community leaders, faith-based organizations, educators, public health departments, and law enforcement. Their goal: to rally the community to end meth use among LGBTQ individuals in LA, especially LatinX users.

ANAM began a petition drive demanding elected and health officials take action against this growing health threat. The Los Angeles County Department of Public Health (Dept. of Public Health) had created a workgroup, "but the workgroup was slow moving and didn't accomplish anything," notes Mr. Zaldivar. What followed was a two-phase grassroots effort to push systems change through community action.

PHASE 1: 2005

Key engagement activities

Identified a full range of community members impacted by meth. Mr. Zaldivar looked broadly to identify the full community affected by meth use. "In 2005, they were Latina homemakers in Los Angeles County, gay and bisexual men, the HIV-positive community, those who frequented business establishments like gay bars and bath houses. We even recruited young people in high schools who were part of the campaign, and faith leaders who were cognizant… of the impact that meth was having among their congregants."

Gathered signatures. Over the course of a year, the ANAM Coalition gathered 10,000 signatures from voters in the area, reaching deep into the community to include everyone impacted by meth use. Importantly, says Mr. Zaldivar, they held press briefings and media events: "When a story comes out in a local newspaper or an ethnic newspaper, and people see a topic that normally is not discussed at the dinner table, they will call and say, 'I want to be part of that.'" ANAM presented its petitions to the Los Angeles County Board of Supervisors in September of 2006. The petition demanded a comprehensive response to the meth epidemic and additional funding for education, research, and treatment.

Launched a community mobilization effort. The ¡Ya Basta! ("enough is enough") campaign uses education, leadership development, and community involvement to address the many challenges in reducing HIV/AIDS risk behaviors among LatinX gay and bisexual men.

Listen as Richard Zaldivar, Founder and Executive Director of The Wall Las Memorias Project, describes ANAM's community outreach efforts.

Outcomes

In 2007, ANAM's petition secured $1.6 million in new government funding for community-based organizations countywide to support meth use treatment and prevention. New government funds were used to spearhead development of and funding for a series of meth task forces. Critically, ANAM's efforts built a sustained partnership network at the community and county level that allowed for continued activism, events, and civic leadership.

PHASE 2: 2019

Key engagement activities

After 2007, ANAM stepped back as new government programs were implemented. But the meth problem in Los Angeles County began to shift: Federal money for the opioid crisis drained attention away from meth, community organizations funded for meth interventions were not meeting the needs of the LGBTQ community, and meth use was again on the rise. In 2019, following the meth-related arrest of California political donor Ed Buck, TWLMP re-activated ANAM. They went back to the community using a multiphase effort in which they:

Hosted community conversations to collect first-person perspectives. From November 2019 to May 2020, ANAM hosted four virtual focus groups and five in-person listening sessions. Participants were identified by using street outreach at the local art walk, promoting the topic to local organizations, and emailing and calling people with whom TWLMP had existing relationships. A total of 70 gay or bisexual, trans, non-binary and cisgendered individuals—including active users of meth and those seeking treatment—as well as health educators and community members participated. These intimate discussions provided fresh insight into the effects of meth on local communities and health service providers.

Hosted a community roundtable to formulate recommendations. In July 2020, ANAM coordinated its first large online forum. Over 140 health and addiction experts, policymakers, and members of the LGBTQ community in Southern California attended. People with lived experience of meth use and dependency presented at the forum along with public health experts, laying out a diversity of perspectives. Following the session, ANAM drafted preliminary recommendations. Over the next two months, ANAM held a series of smaller community dialogues (35 people total) to further develop recommendations for addressing meth use. In October 2020, ANAM convened a third meeting, this time with 25 service providers, to share the work of ANAM and next steps in the campaign.

Convened a government roundtable. In December 2020, ANAM convened a second roundtable with community members and county officials to present recommendations and advance the conversation about addressing meth in Los Angeles. Over 40 public officials participated, and a subset of participants consisting of professionals from relevant fields formed a workgroup to help plan and lead a community summit.

Coordinated a community summit to revise recommendations. Returning to the community, ANAM and the workgroup held a three-part meeting in which over 200 community members participated. Breakout sessions generated specific recommendations on prevention, treatment, and policy ideas related to meth use.

Co-developed a platform paper. The workgroup split into prevention, treatment, and policy subgroups to draft final recommendations. After five months and 54 hours of effort, the resulting four-page platform paper assembled input from 17 community-based organizations (CBOs) and presented their demands and requests for meth prevention, treatment, and policy change. In December 2021, ANAM presented the platform paper to coalition and community members for approval and adoption. Over 40 individuals participated in a line-by-line review.

Outcomes

ANAM engaged almost 600 people at the local, county, and state levels in its effort to create new programs to reduce meth use and advocate for policy change. Twenty-three nonprofits, groups, and community organizations signed on for the new collaboration. The community power is "awesome," as Mr. Zaldivar notes, "because you have some large nonprofit organizations, you have some smaller ones, you have some gay, you have some straight. And they're all working together, having their voice expressed in this Los Angeles County Act Now Against Meth platform." When such efforts succeed, community groups see they have power. "What we also found is that for an underserved community, as they go through this process, there is an increase in self-esteem. They get to see, 'Wow, we can make changes in government if we work together, if we strategize and we execute,' which really is powerful." ANAM planned to deliver its platform paper to the Los Angeles County Board in early 2022.

> *"As they go through this process, there is an increase in self-esteem. They get to see, 'Wow, we can make changes in government if we work together, if we strategize and we execute.'"*
>
> *Richard Zaldivar, Founder and Executive Director of The Wall Las Memorias Project*

ASSESSING COMMUNITY ENGAGEMENT OUTCOMES

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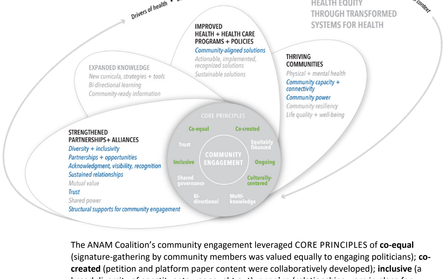

The ANAM Coalition's community engagement leveraged CORE PRINCIPLES of **co-equal** (signature-gathering by community members was valued equally to engaging politicians); **co-created** (petition and platform paper content were collaboratively developed); **inclusive** (a broad diversity of constituents was sought out); **ongoing** (relationships were in place for Phase 2); and **culturally-centered** (strategies for reaching LGBTQ, LatinX, and other under-served constituents were grounded in cultural and social knowledge of these communities).

ANAM's approach to community engagement STRENGTHENED PARTNERSHIPS + ALLIANCES in the form of **diversity + inclusivity** (broad representation of underrepresented voices, such as queer people of color with lived experience of meth use, unhoused individuals, formerly incarcerated individuals, and sex workers); **partnerships + opportunities** (a relationship network that plugs CBOs and community members into related efforts, such as ¡Ya Basta!); and **acknowledgment, visibility, recognition** (TWLMP, the ANAM Coalition, and community partners have received extensive local press coverage). Fifteen years of broad community engagement has produced **sustained relationships** and **trust** (ongoing work and bilateral relationships among community members, CBOs, and Dept. of Public Health partners). The ANAM Coalition remains a robust **structural support for community engagement.**

The ANAM Coalition has IMPROVED HEALTH + HEALTH CARE PROGRAMS + POLICIES through **community-aligned solutions** ($1.6 million in funding issued in 2007 for meth treatment and prevention programs tailored to the needs of LatinX and LGBTQ communities, as well as continued funding for the Los Angeles Department of Substance Abuse and Prevention Control).

Finally, the ANAM Coalition has led to THRIVING COMMUNITIES by building **community capacity + connectivity** and **community power** (helping the LatinX and LGBTQ communities advocate through community organizing to attain community goals, have their voices heard in the State Legislature, change their health and power outcomes, and have hope for the future).

Building Health Equity Zones

How Rhode Island's health equity funding strategy is promoting community power and generating community-level impact.

TIMEFRAME	2015-present
COMMUNITY	A diverse mix of urban, rural, and exurban communities across the state
GEOGRAPHY	Rhode Island
FOCUS	Community-defined
CORE PRINCIPLES	Inclusive, Co-created, Culturally-centered
COMMUNITY ENGAGEMENT OUTCOMES	**Strengthened Partnerships + Alliances** **Expanded Knowledge** **Improved Health + Health Care Programs + Policies** **Thriving Communities**

PROJECT BACKGROUND

The Health Equity Zone (HEZ) initiative is a state-level response to Rhode Island's persistent health inequities. Historically, state-level health funding and data collection have been organized around diseases and conditions (e.g., asthma, diabetes, and obesity), even as research repeatedly documented the role of the local environment in driving differences and disparities in the health status of residents. Furthermore, notes Ana Novais, Assistant Secretary for the Rhode Island Executive Office of Health and Human Services, "we kept providing services instead of investing in communities to define and solve their own challenges." Progress was not being made. However, when state agencies began looking at population health data by geography, their approach started to change.

The resulting HEZ initiative is designed to address the role of environmental, social, and economic factors in community health. Operated by Rhode Island's Department of Health (RIDOH), this initiative directs state dollars to community collaboratives in defined geographic areas whose goals align with RIDOH's leading priorities: 1) address the social and environmental determinants of health in Rhode Island; 2) eliminate health disparities in Rhode Island and promote health equity; and 3) ensure access to quality health services for Rhode Islanders, including its vulnerable populations. The HEZ initiative is RIDOH's place-based, community-led approach to improving health.

HEZs are designed to engage the entire community in the creation of solutions to address local priorities. From the beginning of the application process to the creation of each HEZ through implementation, RIDOH partners with community members. Through a four-year structured development process, HEZ funding creates a platform for neighbors and community partners to come together in new ways and address the root causes of inequitable health outcomes in their neighborhood. Community leadership ensures that the actions taken are culturally competent, socially relevant, and sustainable.

Watch an overview of how HEZs work by Ana Novais, Assistant Secretary for the Rhode Island Executive Office of Health and Human Services.

KEY ENGAGEMENT ACTIVITIES

> *"For me, it's almost an obligation to engage with these local partners and to elevate that voice meaningfully, systematically, purposefully. Not a one-time project, not a grant, but truly relying on these communities to make the impact.*
>
> *Ana Novais, Assistant Secretary, Rhode Island Executive Office of Health and Human Services*

Define a Health Equity Zone. HEZs are proposed and defined by community members but must serve at least 5,000 people. Initially, HEZ boundaries were defined by ZIP codes. However, it became clear that for some communities the better boundary was a neighborhood; for others, such as rural communities, it made more sense to expand to a county level.

Identify a backbone organization. Each HEZ collaborative is anchored by a backbone organization that acts as an administrative center and convening body for other members. Backbone organizations have included local community development corporations, anchor institutions, municipal government offices, and community-based organizations or health centers.

Build a collaborative. A next step is to build, expand, and/or maintain a collaborative of diverse partners to drive the project. These can include residents, municipal leaders, businesses, education systems, health systems, law enforcement, and others.

Assign a facilitator. Many communities have ideas for how to address their health needs, but not all have the skill sets or experience to lead lasting change. A key component of the HEZ strategy is to embed facilitators, who are contracted by the state, into community efforts to provide structure and process and promote community readiness for implementation. Facilitators follow core principles of shared power and have no decision-making authority.

Provide training and technical assistance. RIDOH tailors support services to help HEZs at different stages of development. Services can include mentorship by other HEZs, participation in quarterly Learning Community meetings, external trainings, webinars, and other resources.

Perform a community assessment. In year one, each collaborative is asked to use a place-based perspective to inventory the assets and needs of their community. The purpose of the assessment is to identify and describe issues that are of interest to the community, including the socioeconomic and environmental factors that drive health outcomes.

Develop an action plan. Each collaborative leads its community in a prioritization process to identify solutions they want to implement. HEZ collaboratives are encouraged to select strategies that address root causes of their health inequities and to consider the feasibility, effectiveness, and synergy between selected interventions to effect change within the implementation timeframe. Collaboratives should agree that their HEZ action plan builds from their insights and innovations so they are invested in the implementation process—which also builds readiness.

Implement the action plan. Implementation occurs during years two and three. During this time, HEZs must begin to leverage local resources to supplement the seed funding provided by RIDOH. This will set the collaborative on a path to become a standalone, self-sustaining center for community health.

Evaluate and monitor HEZs. HEZs are encouraged to evaluate their work, funding, and collaborative growth on a quarterly basis. RIDOH also conducts various evaluations to improve the capacities and practices of individual collaboratives, as well as to strengthen the overall HEZ initiative. Metrics and indicators vary by HEZ and are chosen to reveal the success and sustainability of its approach, but also include HEZ characteristics such as diversity and community empowerment.

Watch community members and Dr. Nicole Alexander-Scott, MD, MPH, then Director of the Rhode Island Department of Health, talk about the impact of HEZs on local communities.

PROJECT OUTCOMES

Since its inception, more than $10.4 million in public health funding has been distributed through the HEZ initiative. As of 2021, there were 15 active HEZs across Rhode Island, with at least one in each of the state's five counties. The state has also developed and released a HEZ Toolkit for use by other states and communities interested in creating and building HEZ-like intiatives.

ASSESSING COMMUNITY ENGAGEMENT OUTCOMES

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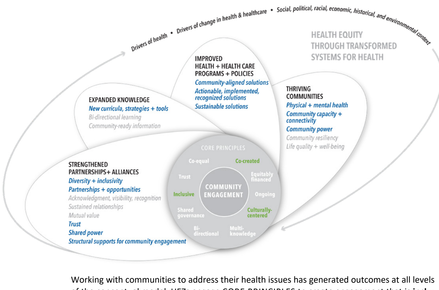

Working with communities to address their health issues has generated outcomes at all levels of the conceptual model. HEZs engage CORE PRINCIPLES to create engagement that is **inclusive** (coalitions include partners at all levels in the community) and **co-created** and **culturally-centered** (communities set the agenda and priorities based on local assets and needs).

While individual HEZs have their own outcome measures, surveys of HEZs in 2017 and 2018 suggest these collaboratives are generating STRENGTHENED PARTNERSHIPS + ALLIANCES through **diversity + inclusivity** (HEZs reach and include residents from urban, rural, and exurban settings and represent each community's racial and ethnic makeup and income levels); **partnerships + opportunities** (partners identify as more connected, some partners have run for elected office, and organizations are stepping forward to join local efforts); **shared power** (partners are more prepared to create mutually reinforcing activities and shared measurement practices, an objective for collective impact); and **trust** (partners report trust is high). By design, HEZs offer **structural supports for community engagement**.

The HEZ initiative has EXPANDED KNOWLEDGE in the form of **new curricula, strategies + tools** (the HEZ funding and development formula is now a repeatable process that has been tested, refined, and formalized for use by other states in the HEZ Toolkit).

Local HEZs have IMPROVED HEALTH + HEALTH CARE PROGRAMS AND POLICIES with solutions that are **community-aligned; actionable, implemented, recognized;** and **sustainable**. Results include: The HEZ in Washington County provided evidence-based mental health first aid and suicide prevention training to more than 1,000 partners; the Central Providence HEZ implemented a Walking School Bus program that boosted school attendance; and multiple HEZs have trained and deployed community health workers to build community-clinic linkages. Sample policy results include a town ordinance banning cigarettes and vaping in parks (Bristol); a Green and Complete Streets ordinance that provides safe access to roads for all users regardless of age, ability, or mode of transportation (Pawtucket/Central Falls); and a Healthy Eating policy at recreation centers (Providence).

Rhode Island HEZs have promoted THRIVING COMMUNITIES by improving **physical + mental health,** as evidenced by a 44% reduction in childhood lead poisoning (Pawtucket); a 24% reduction in teen pregnancy (Central Falls); a 13% reduction in feelings of loneliness (West End, Elmwood, and Southside Providence); a 63% reduction in elementary school absenteeism (Pawtucket); a 39% increase in Supplemental Nutrition Assistance Program (SNAP) sales and 117% increase in new SNAP customers (West Warwick); a 36% increase in access to fruits and vegetables (Central Providence); and 46 people diverted from the criminal justice system to opioid use disorder treatment and recovery services (West Warwick). HEZ participation across the state has also expanded **community capacity + connectivity** and **community power**, as evidenced by a 163% increase in community engagement.