Sustaining Strong Coalitions and Measuring Success

Theresa Green, PhD, MBA

Director, Community Health Education and Policy, URMC
Center for Community Health

Building Bridges and Establishing Community Coalitions is a component of HANYS' *Advancing Healthcare Excellence and Inclusion* learning collaborative, launched with generous support from the Mother Cabrini Health Foundation. This series covers how hospitals can engage local leaders across sectors to build and strengthen community-based coalitions, identify shared priorities, and address health equity concerns.

Agenda

- Introductions
  - Objectives
  - HANYS AHEI team
  - Our funder and partner
  - Our faculty
- Session 3: *Sustaining strong coalitions and measuring success*
- Resources
- Next steps
- Questions

Objectives

By the end of this session, participants will be able to:

- Build sustainability planning into the coalition's work;
- Use data to craft an impactful story to share with community members;
- Establish metrics to evaluate the success of the interventions developed to address health inequity and the overall success of the coalition; and
- Identify population health data to support evidence-based interventions and address health disparities and social inequities.

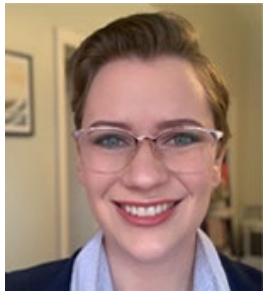
HANYS AHEI team

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, Advancing Healthcare Excellence and Inclusion

Maria Baum, MS, RN, CPHQ

Project Manager, Mohawk Valley

Rachael Brust

Project Manager, North Country

Kira Cramer, MBA

Project Manager, Downstate

Our funder and partner

Mother Cabrini HEALTH FOUNDATION

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.

DataGen® Insights for Healthcare

OUR PARTNER

Through a partnership with Socially Determined, provider of Social Risk Intelligence™ solutions, DataGen will develop custom analytics for participants to help them understand how and where communities are affected by social risk so they can develop tailored intervention strategies.

Our faculty

Theresa Green, PhD, MBA

Director of Community Health Policy and Education
URMC Center for Community Health
Bio

Julia E. Iyasere, MD, MBA

Executive Director
Dalio Center for Health Justice at New York-Presbyterian
Bio

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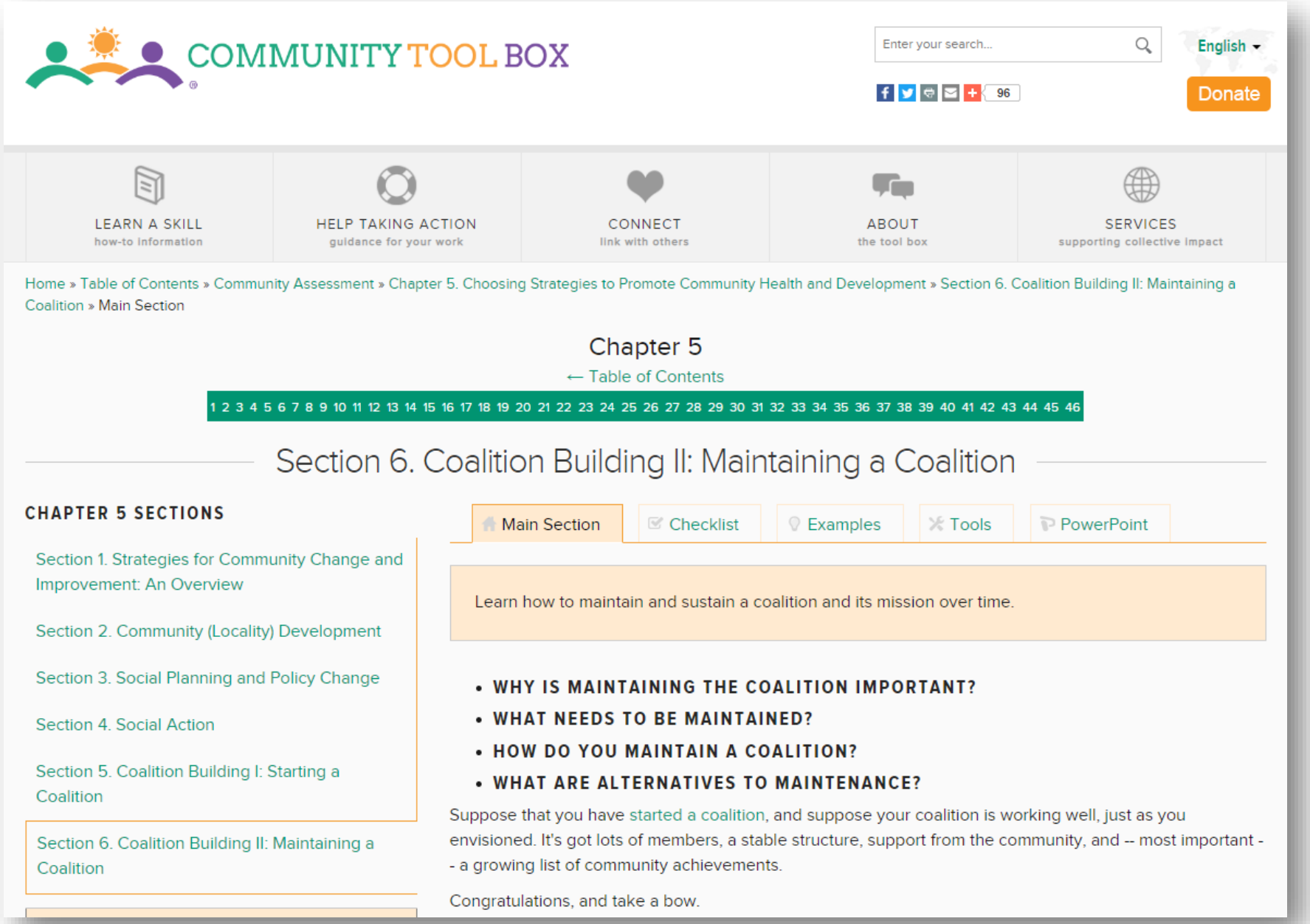
Session 3 – Next steps

- We recognize that community engagement is important
- We have clearly articulated a problem statement that addressed health equity
- We have identified stakeholders to engage – both internal and external
- We have crafted an “ask” that is respectful of history and aware of any distrust or apprehension
- We have a mapped a strategy to engage the stakeholder and have created (or joined) a coalition…

Now what?

Maintaining the Coalition

Set up the coalition with sustainability in mind.



[Community Tool Box, Center for Community Health and Development, University of Kansas: Maintaining a Coalition]

Coalition Maintenance

- Key point about maintenance is that it won't happen all by itself. It takes effort -- conscious, planned, and ongoing.
- What needs to be maintained are the key structures, functions, and relationships of the coalition that helped get it started in the first place.

Considerations:

- The coalition's reason for being-its vision, mission and objectives
- The basic governance and operating rules of the coalition
- The coalition leadership
- The coalition membership
- The division of labor, within and among the leaders and members
- The coalition's strategic and action plans, both short-and longer-term
- The coalition's actions and results, so that it is accomplishing something (what it means to) in the world
- The coalition's funding, so that those accomplishments can be continued
- The coalition's visibility in the larger community
- The coalition's public support
- The spirit of the coalition, the good feelings and relationships among all involved

QUESTION:

Think about a coalition that you enjoy being a part of. WHY do you like being a part of this group? (ranking maybe)

- Mission of the coalition is in line with my goals
- Meetings are fun and interactive
- Coalition is respectful of my time/meetings are efficient
- I can see progress in the work we are doing
- I learn from the other coalition members

Sustainability

New York State Health Foundation Sustainability Toolkit

Suggests choosing 3-4 factors to sustain a project

SUSTAINABILITY DEFINITION:

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

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.

APPENDIX A

SUSTAINABILITY FACTORS:
DEFINITIONS AND EXAMPLES

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.

ADVANCING HEALTHCARE EXCELLENCE AND INCLUSION

HANYS Always There for Healthcare

Organizational Infrastructure

Organizational operations should support the work and be consistent with the goals and infrastructure of participating organizations

- Who is leading the group? Need a CHAMPION!
- Who is providing staff support?
- What is the ideal group size? What positions are needed at meeting?
- When is the group meeting? How is the group meeting? Where is the group meeting?

Example 1:

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 resource.

UR MEDICINE

Strong Memorial Hospital

Highland Hospital

ROCHESTER REGIONAL HEALTH

Rochester General Hospital

Unity Hospital

Monroe County Department of Public Health

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COMMUNITY HEALTH IMPROVEMENT WORKGROUP

QUESTION:

What level on organizational positions would be most effective for this group?

- Representatives should be high level leaders – CEOs, etc.
- Representatives should be mid-level leaders – Managers, VPs, etc.
- Representatives should be boots-on-the-ground workers
- Level of representation is not important

REPRESENTATION

AGENCY	Representative
Monroe County Department of Public Health	Michael Mendoza Mariélena Velez de Brown, Anne Kern, Kathy Carelock
Rochester Regional Health Rochester General and Unity Hospitals	Bridgette Wiefling Katie Sienk, Alise Gintner, Natalie Golub
University of Rochester Medical Center Strong Memorial Hospital	Kathy Parrinello Wendy Parisi, Mardy Sandler with Lisa Lagana, Melissa Molongo
University of Rochester Medical Center Highland Hospital	Cindy Becker Timothy Holahan with Maureen Malone
Center for Community Health & Prevention	Theresa Green, Dan Green
Monroe County Office of Mental Health	Jessica Watington, Jason Teller
Rochester RHIO	Elizabeth Bailey
Common Ground Health	Linda Clark, Catie Kunecki, Lucas Sienk, Dina Faticone
FLPPS	Katherine Rogala
City of Rochester	Elizabeth Murphy
United Way	Nikia Washington
Monroe County Medical Society	Lucia Acosta-Castillejo
2-1-1 Lifeline	Jordan Marsh
Cornell Cooperative Extension	Andrea Lista
Systems Integration	Laura Gustin
African American Health Coalition	Florence Dukes

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COMMUNITY HEALTH IMPROVEMENT WORKGROUP

Communication

- Meetings monthly, agenda sent ahead of time
- Minutes to participants, cc: senior leadership
- Newsletter to anyone interested
- Meetings are 90 minutes, held virtually, same leader each meeting
- Meetings include updates, informational presentations (20 min max)
- Discussions among whole group, usually 10-15 people

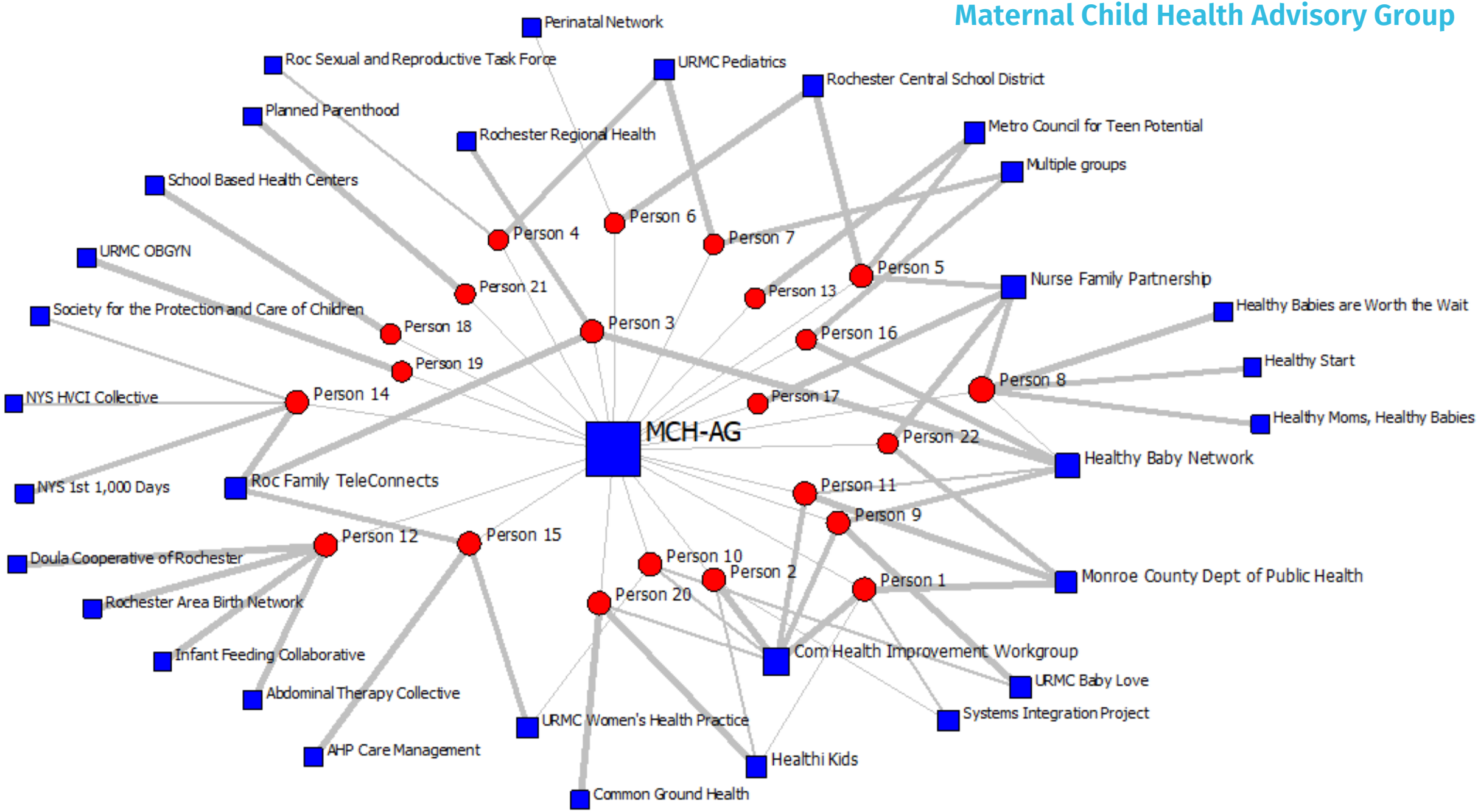
Maternal Child Health Advisory Group

- An advisory group of content experts for the CHIW
- Build a connected network of perinatal health related professionals with community based agencies to address social determinants of health

What level of organizational positions would be most effective for this group?

- Over 80 members from over 35 agencies, departments or organizations

Maternal Child Health Advisory Group



Communication

- Meetings quarterly, agenda sent ahead of time (30-40 attendees)
- Minutes to participants (80), news blasts as needed
- Meetings are 90 minutes, held virtually, same leader each meeting
- Meetings include updates, informational presentations (30 min max)
- Lots of networking and discussion time, usually breakout discussions but some with the whole group

PERCIEVED VALUE

Project activities being considered are potentially beneficial to clients, service providers, and community members

How do you create activities that move towards addressing the goals of the coalition?

QUESTION:

Of all the coalitions or partnerships you are engaged in, how many of them are action oriented with specific measurable goals?

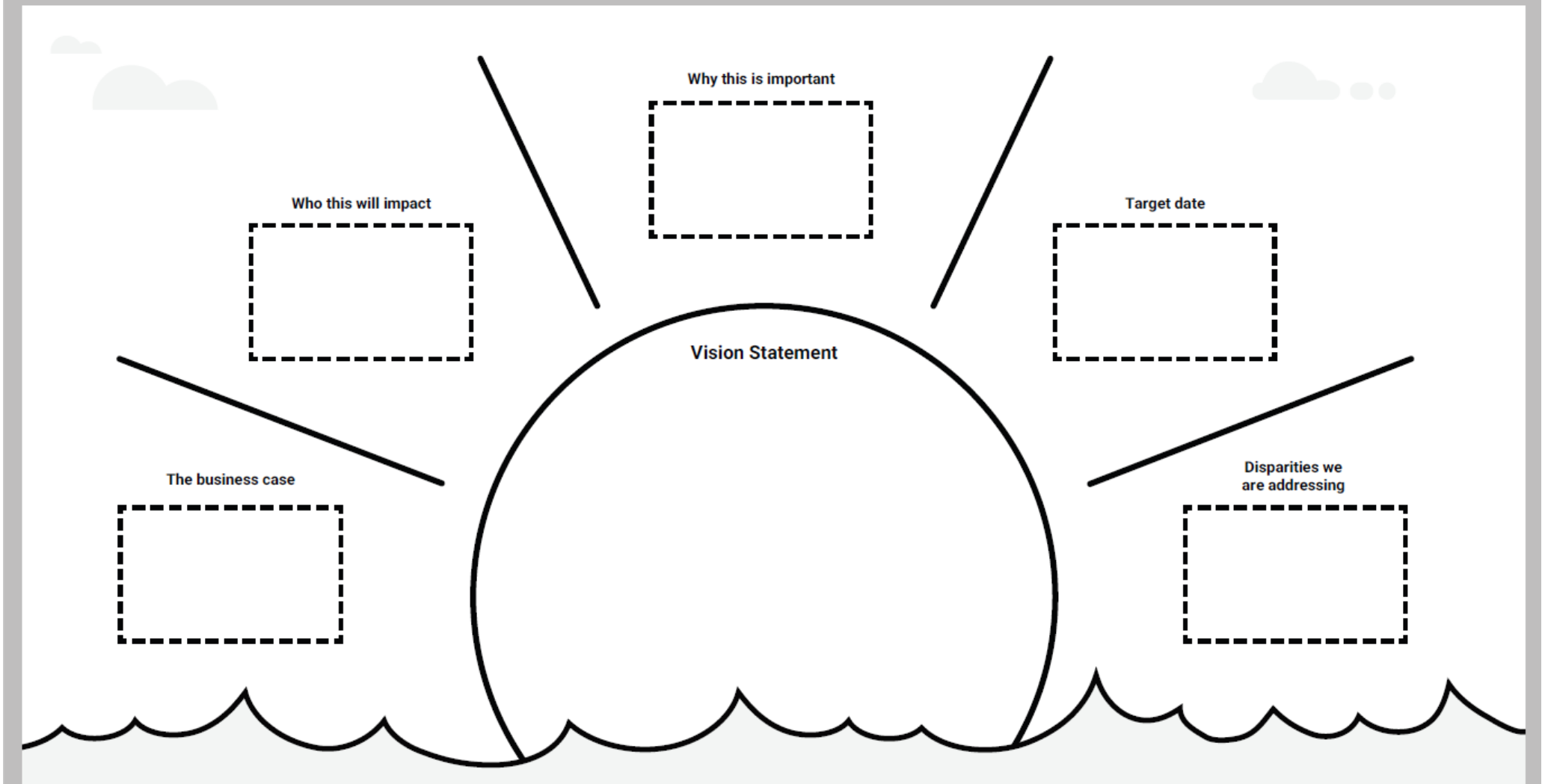
- All of them
- More than half
- Less than half
- Very few

Vision Canvas

Team Name

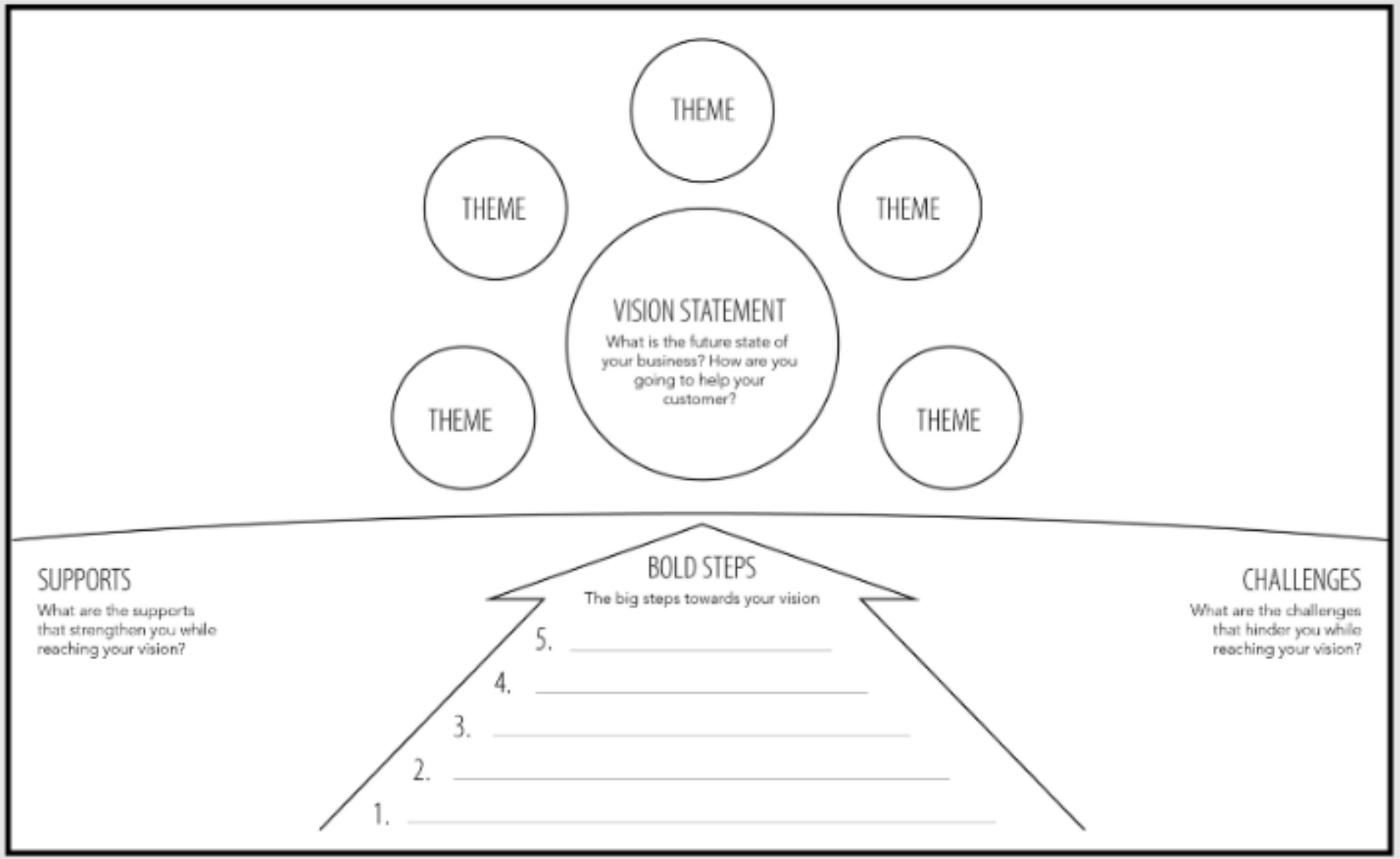
Date

designed by do tank
Business design, redesigned.



5 BOLD STEPS VISION® CANVAS

DESIGN A BETTER BUSINESS



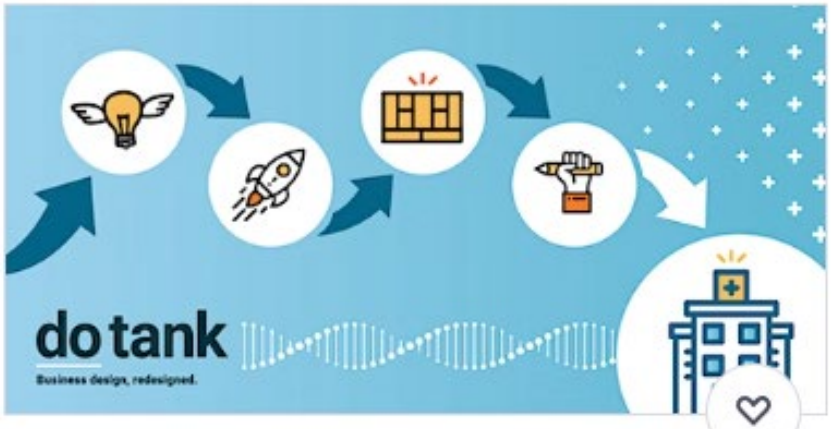
5 Bold Steps Vision Canvas: https://www.designabetterbusiness.tools/tools/5-bold-steps-canvas

https://www.eventbrite.com/o/do-tank-12435572903

Events

Events

Upcoming (2) Past (56)



Applying Human-Centered Design to Improve Healthcare

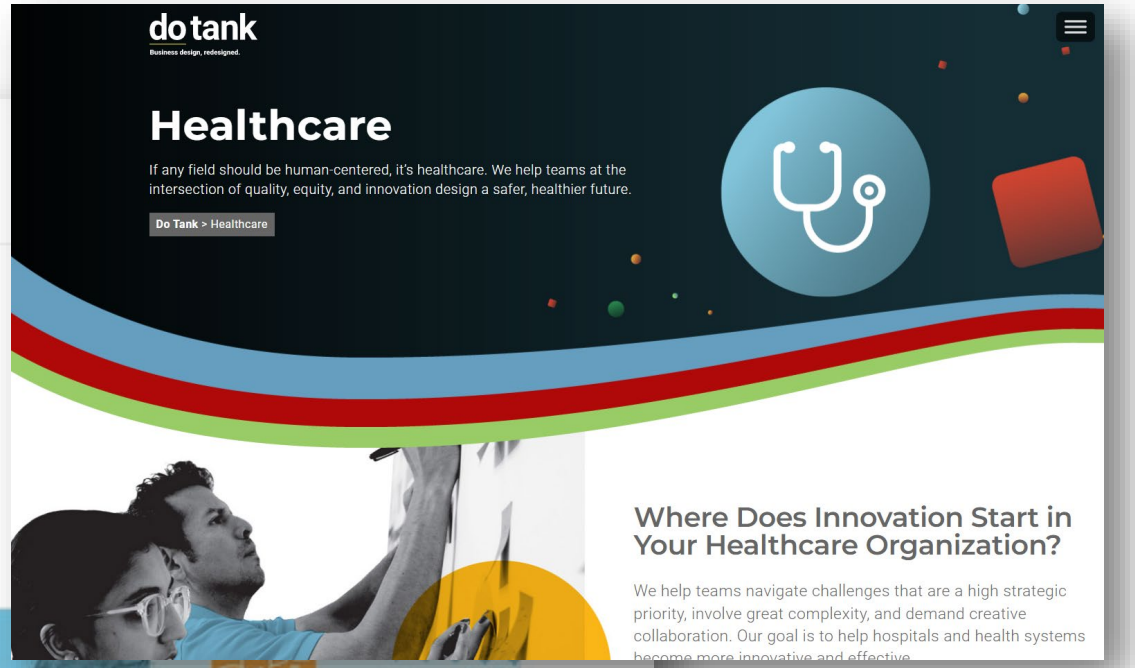
Tue, Oct 25, 2022 1:00 PM EDT

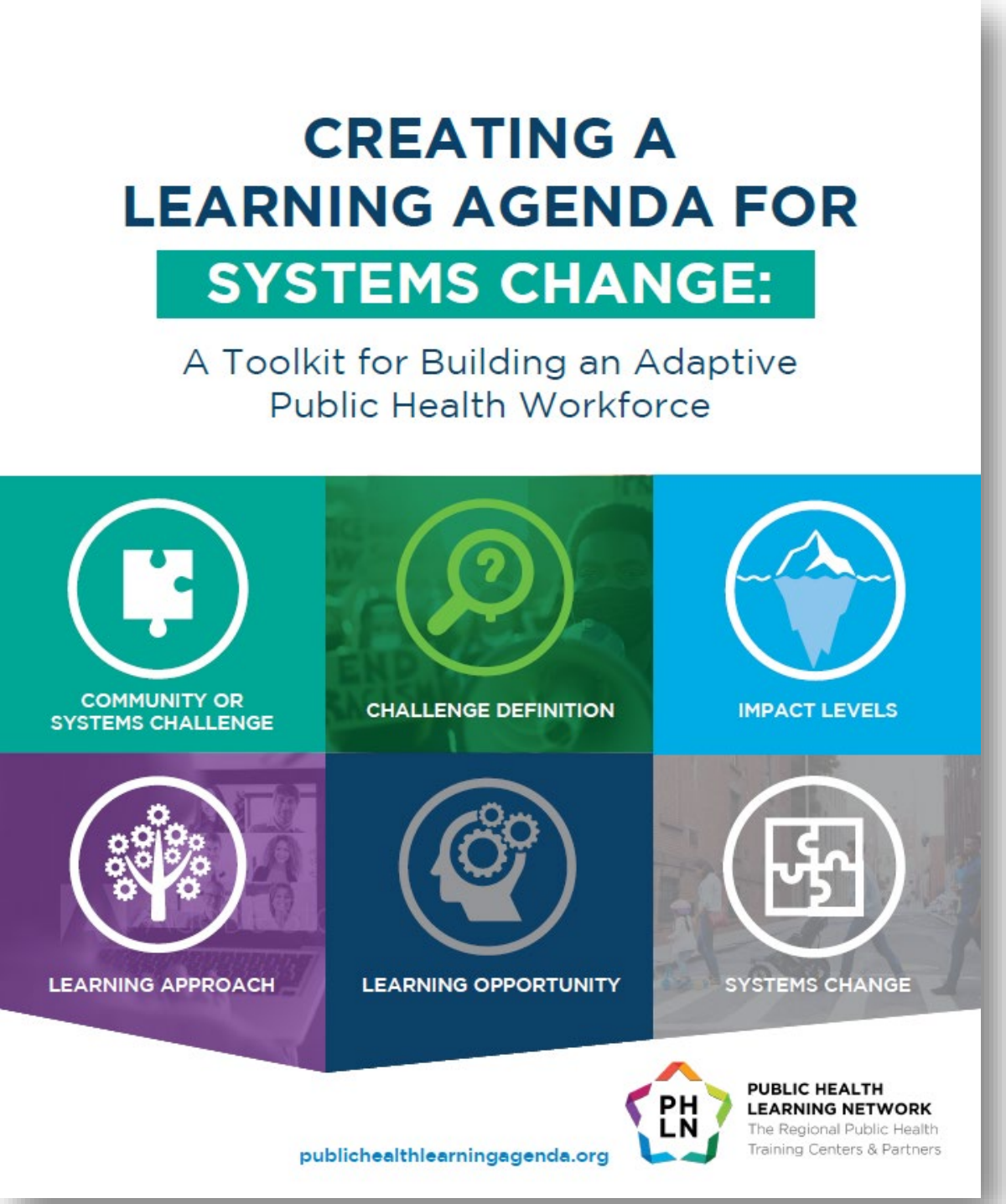
Free

What's in a Story? Craft Narratives that Inspire Change in Healthcare

Tue, Nov 8, 2022 1:00 PM EST

Free



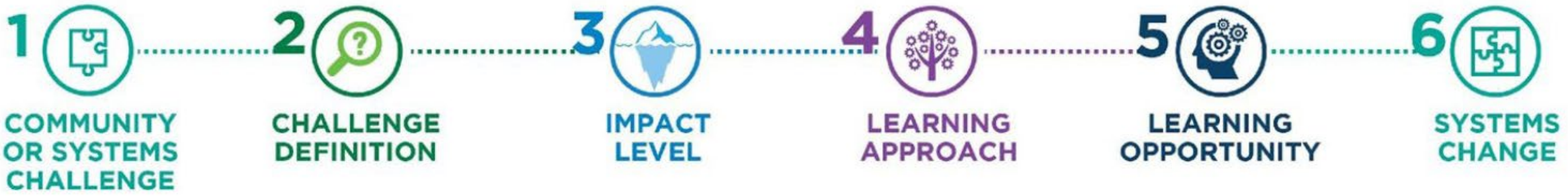


In the Toolkit…

1. **Rapid Self-Assessment Tool** – assesses an organization's current learning state
2. **Discussion Guide** – helps to guide deep discussions about each step of the Learning Framework
3. **Learning Approach Planning Tool** – assists in designing the learning opportunities that will best fit the challenge type and desired level of impact

THE LEARNING FRAMEWORK:
A Conceptual Framework for a Learning Agenda

PUBLIC HEALTH TRAINING CENTERS & Partners



Focus on the **challenge**

Focus on the **desired impact and learning**

www.publichealthlearningagenda.org

Step 1: Understand the Community or System Challenge

Step 2: Define the Challenge

- Write a problem statement with the coalition
- Explore the problem completely (do not consider solutions)
- Get to the **ROOT CAUSES** of the problem (Root Cause Analysis tools)
- Be specific
- Map the process to help define the specific problem you want to address

NEXT: Map the SOLUTION

What would the perfect future system look like?
Do not limit your vision by reality, just dream big!
Ask “if the system worked perfectly, what would it look like?”

How do we get from the current system to the future vision?

Impact Level?

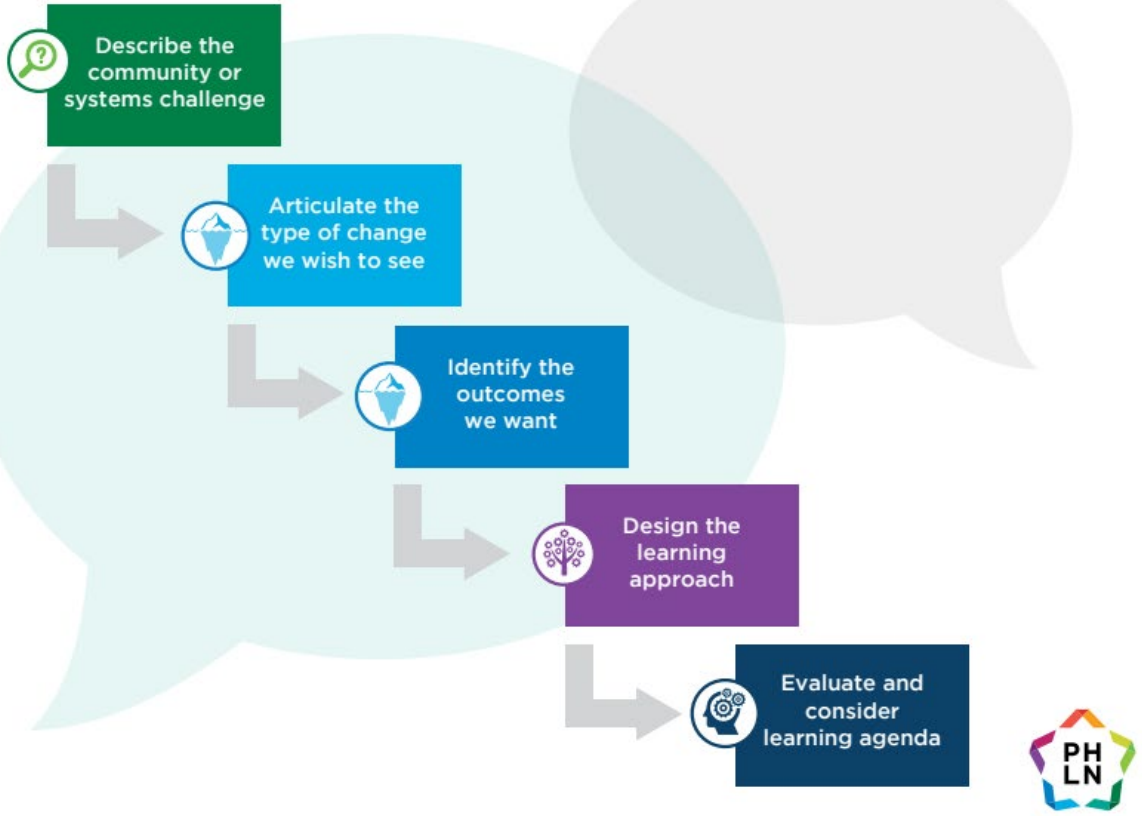
- Level 1: Changing knowledge and skills
- Level 2: Changing policy and practice
- Level 3: Culture change

Learning Approach

- Length and dose of intervention
- Who needs to participate and scope of participation
- What is the necessary format?

Plan, implement and evaluation the intervention (learning opportunity)

Tool 2: Discussion Guide



Welter, C., Barrett, K., Davis, S., Lloyd, L., Rose, B. Creating a Learning Agenda for Systems Change: A Toolkit to Build an Adaptive Public Health Workforce (2020). Public Health Training Centers.

Illustrative Questions from Discussion Guide: (See Appendix for full tool)

Section 1: Describe the community or systems challenge.

Questions in this section are designed to gain further insight into the community or system challenge the organization wishes to address, such as:

- Is it a technical challenge? Can the challenge be clearly defined?
- Is it an adaptive/complex challenge? Does solving the challenge require changes in values, beliefs, roles, relationships, or approaches?
- Is it somewhere in between? Perhaps the challenge is well-defined but difficult to solve.

Section 2: Articulate the type of change we wish to see.

Questions in this section are designed to flesh out the changes the organization is seeking, such as:

- What is the goal?
- What do you want to be different – at the individual level? organizational level? community level?

Section 3: Identify the outcomes we want.

Questions in this section help to further clarify the goals and outcomes desired by the organization, such as:

- What should learners know or be able to do after this learning opportunity?
- What results will show that the learning opportunity was successful and worthwhile?
- What is needed to translate learning to change/application?

Section 4: Design the Learning Approach.

Questions in this section consider the learning conditions that will help achieve the desired outcomes, and how individual learning opportunities can be layered in order to address complex community challenges, such as:

- Should participants be learning individually, with a group, or with a cohort from their organization or community?
- How do participants need to engage with the content or practice what they are learning in order to successfully apply their learning afterwards?
- How much time is needed?
- How will this learning opportunity build upon learning achieved through previous opportunities?
- How will this opportunity prepare the workforce to progress to deeper levels of learning moving forward?

Section 5: Evaluate and consider the Learning Agenda.

Questions in this section determine how to evaluate the learning opportunity, such as:

- Did the learning opportunity achieve its intended goals? How can we improve it in the future?
- To what extent has the community or systems problem been addressed?

Goal 1: Promote Healthy Women, Infants and Children

Objective 1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child populations.

Metric	2022 Baseline	Goal by July 2025
Maternal Morbidity & Mortality Disparities	MC Mortality rate = 29.7/100,000 Morbidity: Black non-Hispanic = 141 vs. White non-Hispanic = 66 (per 10,000 live births)	NYS Goal = 16 Move from “Worsening” to “Improving”
Infant Mortality Disparities	MC Rate = 7.1/1,000 live births Black infants = 16.9/1,000 live births White infants = 3.9/1,000 live births	NYS Goal = 4.0 Move from “No significant change” to “Improving”
% of Preterm Births (Delivery <37 weeks)	Monroe County = 10.4% All County = 9% High risk zip codes = 11.9%	NYS Goal = 8.3% Move from “No significant change” to “Improving”
Suicide mortality – youth (15-19 year olds)	Monroe County = 10.6/100,000 MC Youth attempting suicide = 8% Rochester Youth attempting = 10%	NYS Goal = 4.7 Move from “Worsening” to “Improving”

What do we do about it?

The MCH-AG reviewed the results of several recent focus groups conducted with Rochester community members around issues related to disparities in maternal and child health outcomes. After several discussions about these various results, the group discussed the drivers and potential solutions. These discussions led to the prioritization of three key areas: birth spacing, housing, and institutional racism for the future work of the MCH-AG.

Birth Spacing

Housing

Institutional Racism

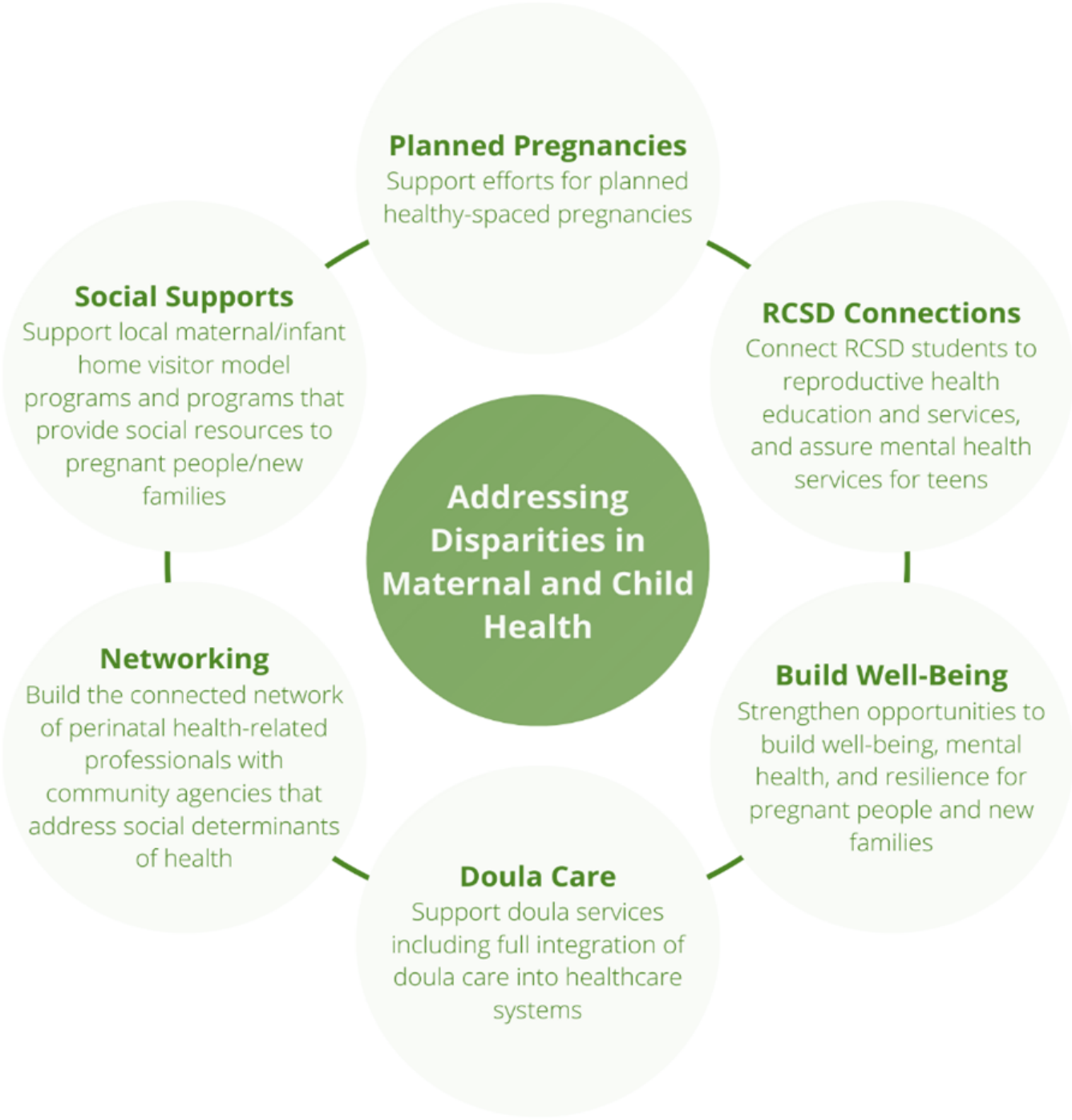
But what are we doing to improve in these areas?

Plans for 2022 - 2024

GOAL 1: Promote Healthy Woman, Infants and Children

Objective 1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child populations.

Last meeting: Breakouts and implementation of the "Learning Agenda for Systems Change"



Monitoring and Feedback

Monitor on a regular basis and share feedback in easy to understand formats. Track progress! Celebrate successes

Create an evaluation plan

Phases and Types of Evaluation

Program Stage	Before Program Begins	New Program	(More) Established Program	Mature Program
Phase	FORMATIVE		SUMMATIVE	
Evaluation Type	Needs Assessment	Process Evaluation	Outcome Evaluation	Impact Evaluation
(Some) Questions Asked	To what extent is the need being met? What can be done to address this need?	Is the program operating as planned?	Is the program achieving its short-term outcomes/ objectives?	Is the program achieving it's long-term outcomes and impacts??

Based on slides from Jennifer Nichols, Porter Novelli
**Credit to NCCOR Collaborative Learning Session 1

NCCOR National Collaborative on Childhood Obesity Research

SESSION 2: COLLABORATIVE LEARNING PROJECT

Evaluation plan includes the ultimate goal – population health impact, however changes here take a long time!

Identify process and outcomes metrics and report changes to the coalition.

Review Population Health Data and Evidence-Based Interventions

- Healthy People 2030
- Census data
- County Health Rankings & Roadmaps
- New York State Prevention Agenda Indicators
- County Departments of Public Health
- Community Health Needs Assessments
- 500 Cities Project
- Etc., etc., etc.…

U.S. Department of Health and Human Services | ODPHP | Office of Disease Prevention and Health Promotion

Objectives and Data | Tools for Action | About | Custom List (0)

Healthy People 2030

Search

HEALTHY PEOPLE 2030

Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade.

Browse objectives by topic

355

Healthy People 2030 includes 355 core — or measurable — objectives as well as developmental and research objectives.

Learn more about the types of objectives.

Leading Health Indicators ★ LHI

Leading Health Indicators (LHIs) are a small subset of high-priority objectives selected to drive action toward improving health and well-being.

Learn about Leading Health Indicators

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

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A just recovery to **achieve economic security and health for all**

The COVID-19 pandemic both revealed and worsened barriers to health and well-being such as racism, discrimination and disinvestment. As we emerge from the pandemic, we can pursue a just recovery that addresses urgent needs and attends to long-standing harms. The 2022 County Health Rankings National Findings Report examines the issues and opportunities to ensure economic security and health for all through a living wage, fair pay for women, affordable and accessible childcare, and well-resourced, equitably funded schools.

Read the report →

How healthy is your community?

Search by State, County, or ZIP Code (e.g. New Mexico, Los Alamos, 87544)

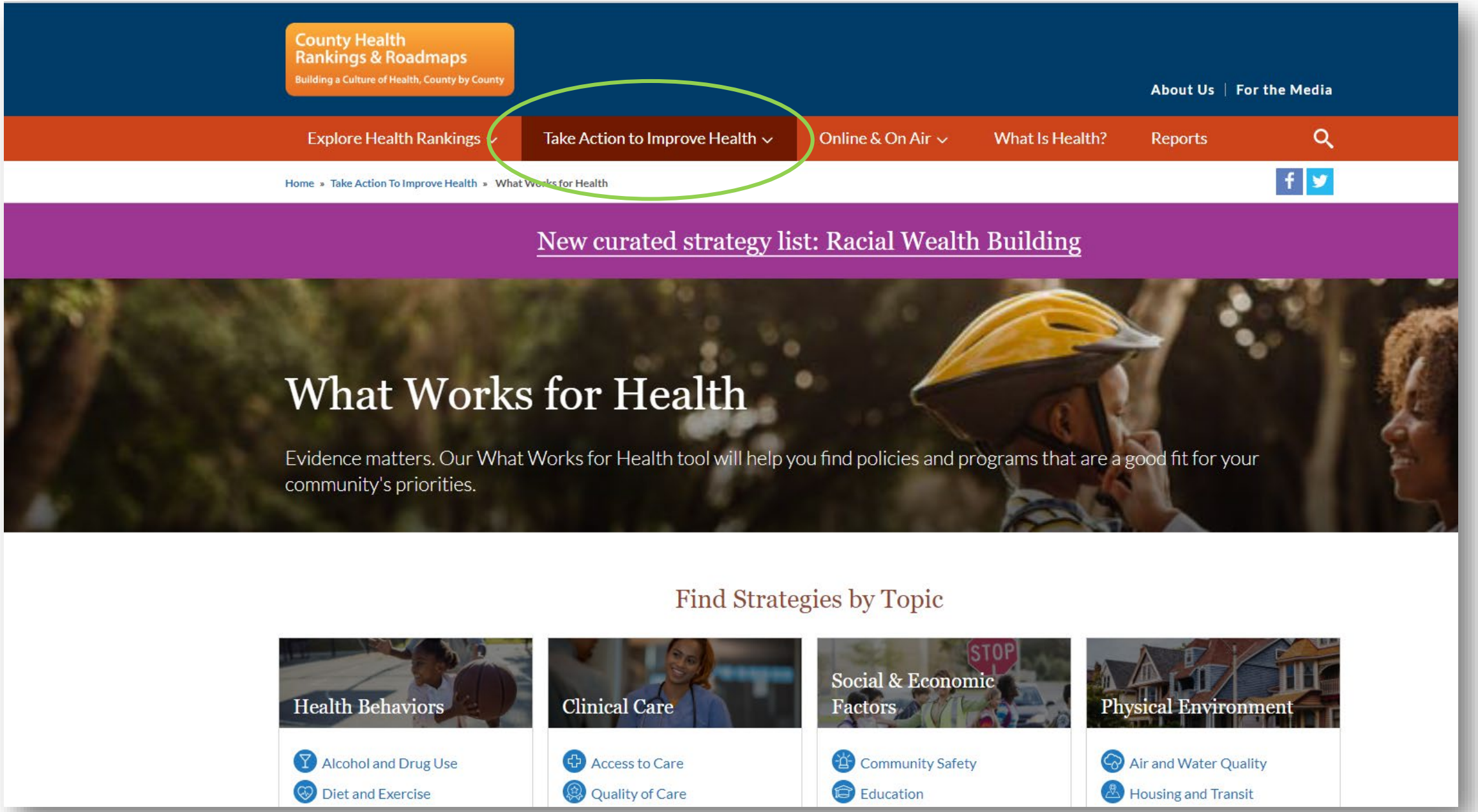
Monroe

Search

Monroe County

	Monroe (MN) County	Trend	Error Margin	Top U.S. Performers	New York
Length of Life					
Premature death	6,800		6,600-7,000	5,600	6,000
Quality of Life					
Poor or fair health	17%		15-19%	15%	16%
Poor physical health days	3.7		3.5-4.0	3.4	3.6
Poor mental health days	4.5		4.2-4.7	4.0	3.9
Low birthweight	9%		8-9%	6%	8%
Additional Health Outcomes (not included in overall ranking) +					
Health Factors					
Health Behaviors					
Adult smoking	18%		15-20%	15%	13%
Adult obesity	32%		31-33%	30%	27%
Food environment index	8.0			8.8	9.0
Physical inactivity	28%		26-31%	23%	27%
Access to exercise opportunities	85%			86%	88%
Excessive drinking	19%		18-19%	15%	19%
Alcohol-impaired driving deaths	20%		17-23%	10%	20%
Sexually transmitted infections	780.2			161.8	640.6
Teen births	14		13-15	11	13
Additional Health Behaviors (not included in overall ranking) +					
Clinical Care					

Clinical Care					
Uninsured	4%		4-5%	6%	6%
Primary care physicians	920:1			1,010:1	1,180:1
Dentists	1,170:1			1,210:1	1,190:1
Mental health providers	320:1			250:1	310:1
Preventable hospital stays	4,420			2,233	3,717
Mammography screening	44%			52%	43%
Flu vaccinations	52%			55%	49%
Additional Clinical Care (not included in overall ranking) +					
Social & Economic Factors					
High school completion	91%		90-91%	94%	87%
Some college	75%		73-76%	74%	70%
Unemployment	8.6%			4.0%	10.0%
Children in poverty	20%		18-23%	9%	17%
Income inequality	4.9		4.8-5.1	3.7	5.7
Children in single-parent households	33%		31-34%	14%	26%
Social associations	9.1			18.1	8.1
Violent crime	326			63	379
Injury deaths	82		79-85	61	53
Additional Social & Economic Factors (not included in overall ranking) +					
Physical Environment					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Reports
Home » Take Action To Improve Health » What Works for Health
New curated strategy list: Racial Wealth Building
What Works for Health
Evidence matters. Our What Works for Health tool will help you find policies and programs that are a good fit for your community's priorities.
Find Strategies by Topic
Health Behaviors
Alcohol and Drug Use
Diet and Exercise
Clinical Care
Access to Care
Quality of Care
Social & Economic Factors
Community Safety
Education
Physical Environment
Air and Water Quality
Housing and Transit

Other data sources

Interventions

NEW YORK STATE

Services News Government COVID-19

Department of Health

Individuals/Families Providers/Professionals Health Facilities Health Data About Us Search

Overview

- Prevention Agenda 2019-2024
- Prevention Agenda Dashboard
- State Health Assessment 2018
- Community Health Planning Guidance
- Community Health Planning Data
- Contact Information for Local Partners

Action Plans

- Prevent Chronic Diseases
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Well-Being and Prevent Mental and Substance Use Disorders
- Prevent Communicable Diseases

News

- 2019 POPULATION HEALTH SUMMIT VI

You are Here: Home Page > NYS Health Initiatives > Prevention Agenda 2019-2024: New York State's Health Improvement Plan

Prevention Agenda 2019-2024: New York State's Health Improvement Plan

The Prevention Agenda 2019-2024 is New York State's health improvement plan, the blueprint for state and local action to improve the health and well-b
experience disparities. In partnership with more than 100 organizations across the state, the Prevention Agenda is updated by the New York State Public
This is the third cycle for this statewide initiative that started in 2008. New to this 2019-2024 cycle is the incorporation of a Health Across All Policies app
the ways that their policies and programs can have a positive impact on health. It embraces Healthy Aging to support New York's commitment as the first

Prevention Agenda 2019-2024: An Overview (PDF, 317KB, 16pp.)

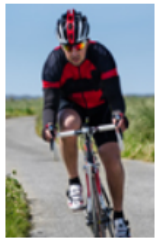
The Prevention Agenda Dashboard - Tracking the Prevention Agenda's Progress.

New York State Health Assessment 2018

Development Process of the Prevention Agenda 2019-2024

Note the left side bar contains links to additional information in support of the Prevention Agenda including data, contact information, and other plan

Action Plans

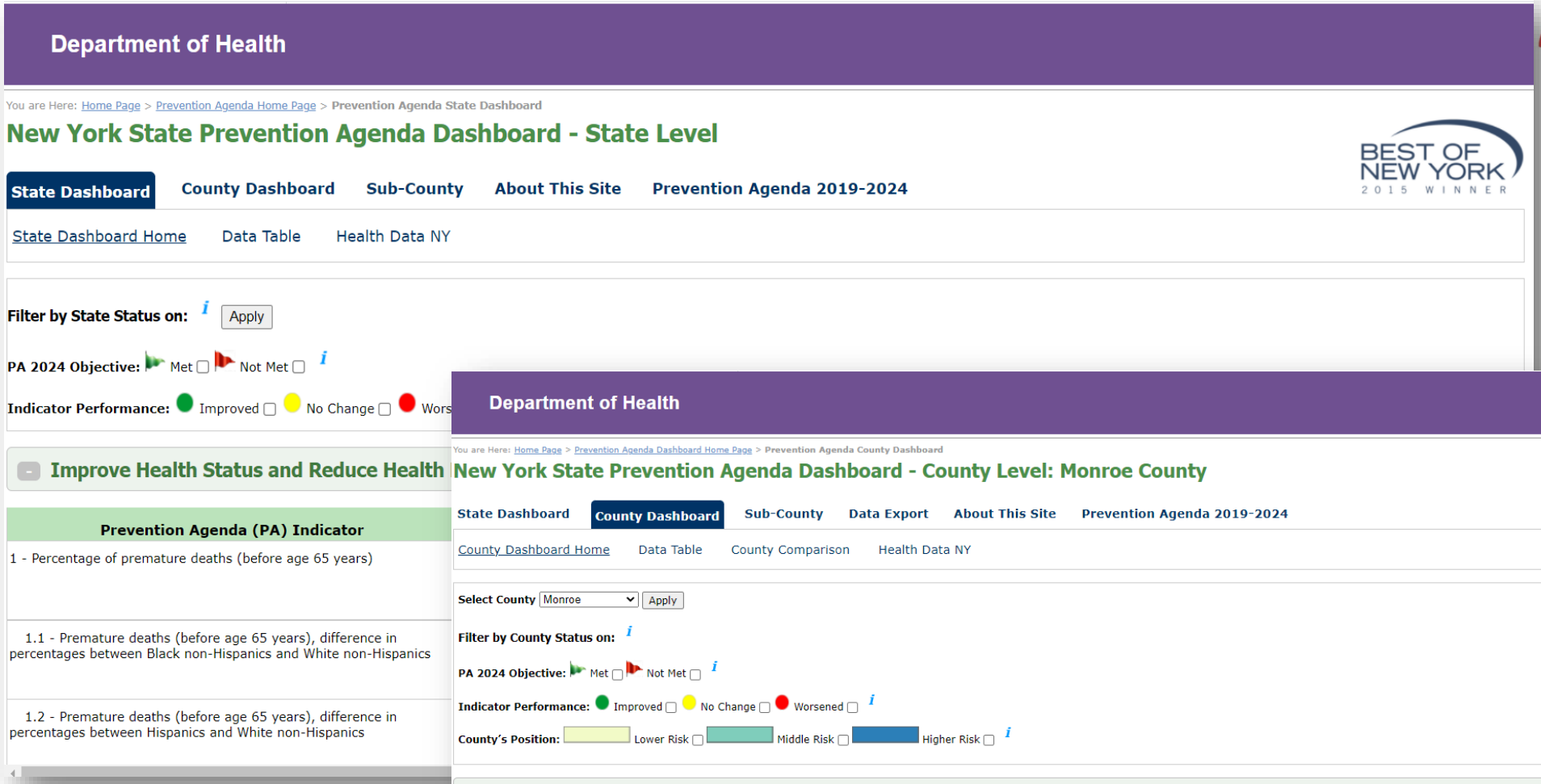


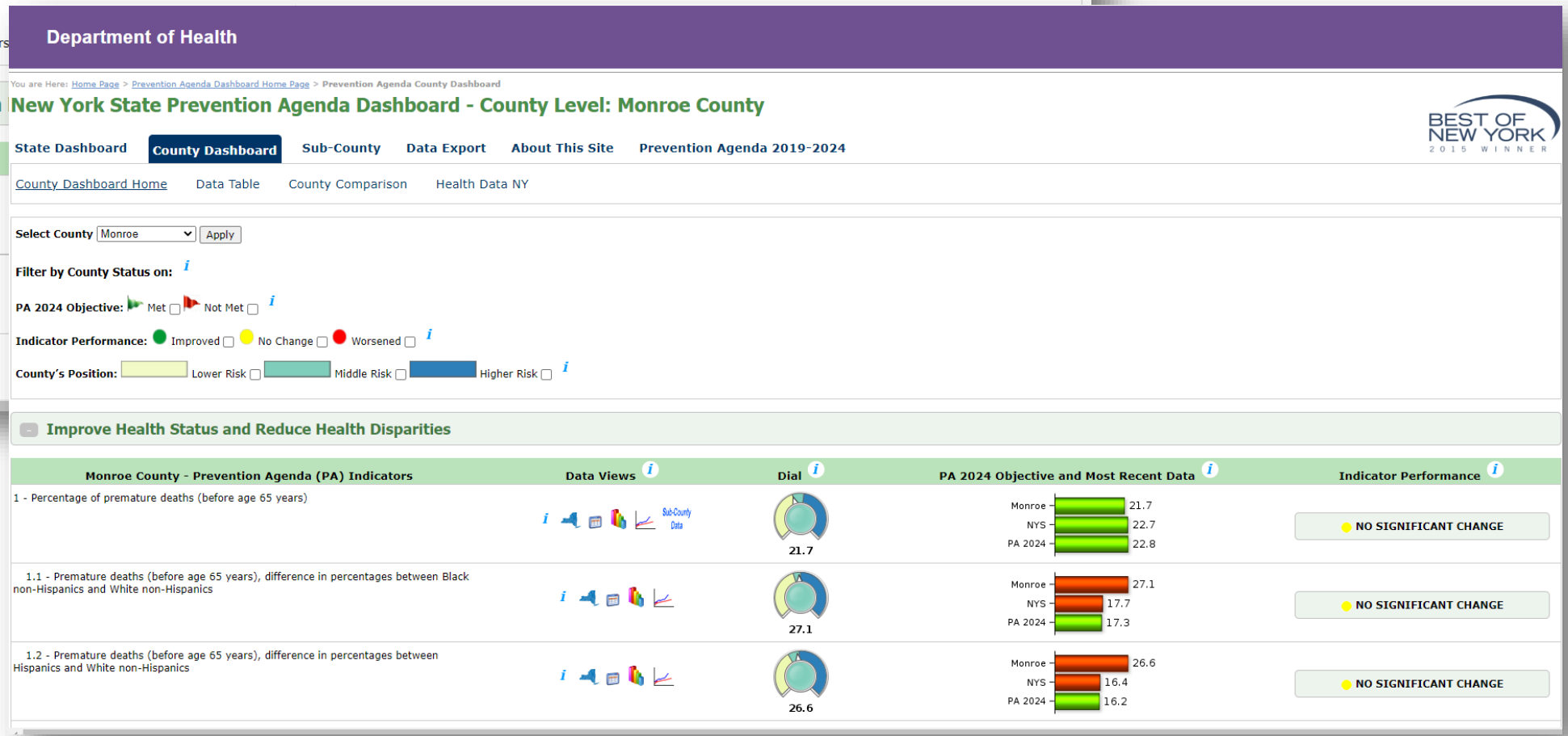
Prevent Chronic Diseases Action Plan

Focus Area 1 - **Healthy Eating and Food Security**
Focus Area 2 - **Physical Activity**
Focus Area 3 - **Tobacco Prevention**
Focus Area 4 - **Chronic Disease Preventive Care and Management**

Promote a Healthy and Safe Environment Action Plan

Focus Area 1 - **Injuries, Violence and Occupational Health**
Focus Area 2 - **Outdoor Air Quality**
Focus Area 3 - **Built and Indoor Environments**
Focus Area 4 - **Water Quality**
Focus Area 5 - **Food and Consumer Products**





Over-arching Intervention: Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.

Proposed Actions	Short term Outputs/Outcomes	Intermediate Metrics
A. Networking Build the connected network of perinatal health-related professionals with community agencies that address social determinants of health • Fully support the MCH-Advisory Group with meetings and resource sharing • Continue advisory support for ROC Family Teleconnects Screening program (RRH, URMC)	• # of MCH-AG meetings • # of speakers addressing social determinants of health, especially housing and racism *Target: 4 meetings/year with 1 speaker/meeting each year*	• # Collaborations, reach and/or programs resulting from MCH-AG network • # Advocacy towards addressing social determinants of health especially housing and racism *Target: Increase in depth of relationships, increase density of network analysis by 2024*
Reducing Maternal Morbidity and Mortality particularly for Black People giving Birth		
B. Doula Care Support doula services including full integration of doula care into healthcare systems • Support the Black Doula Collaborative to increase Doula's to serve BIPOC community (FLPPS, HBN, Finger Lakes Health, and HealthConnect One, RRH) • Educate the existing network of social workers and care managers at both health systems	• # Opportunities for hospital staff to learn with doulas and/or about doula care • # Advocacy efforts for Doula Support *Target: 4 educational opportunities in year 1*	• # Healthcare systems integrated with doula care (policies & procedures in place for Doulas) • # Patients who wanted Doula care & received it. *Target: 4/4 hospitals with Doula policies, procedures, 100% patients served by 2024*
C. Build Well-Being Strengthen opportunities to build well-being, mental health, and resilience for pregnant people and new families	• Use of community-based resources • # programs linking pregnant and young families to housing and food resources • Integration of mental health and resilience resources to new families *Target: Identification and sharing of resources, 2 new programs in year 1*	• Consider a survey of community members – esp. pregnant/new families assessing barriers to support • Food insecurity and housing insecurity rates among pregnant and new families *Target: Pre and post survey implemented, decrease in social need among new families for 2024*

Planned Activities:
- Share and support resources such as the Gender Wellness Center (URMC), Parenting Village, Beautiful Birth Choices
- Continue the Whole Child Initiative (RRH)

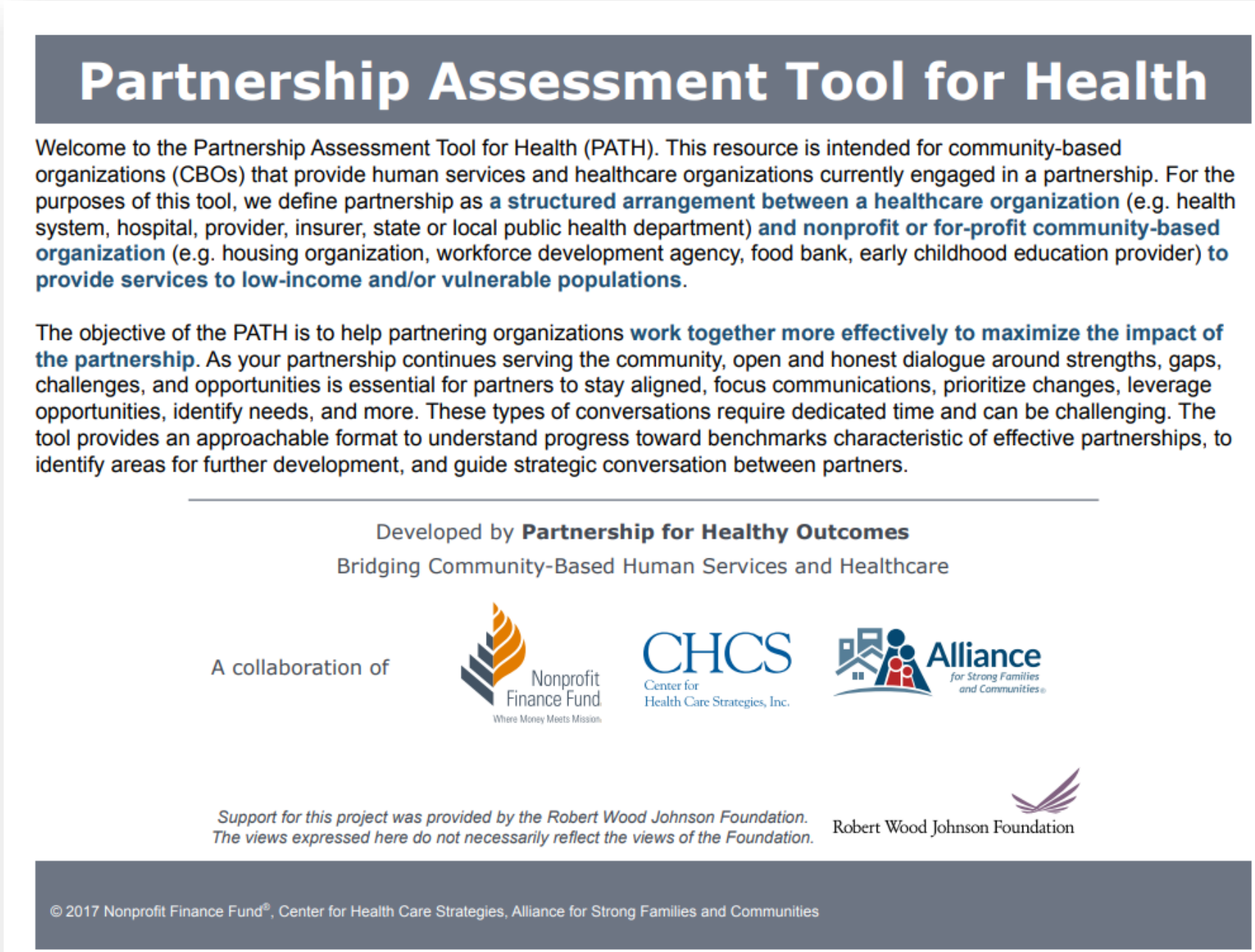
ADVANCING HEALTHCARE EXCELLENCE AND INCLUSION

HANYS Always There for Healthcare

Overarching goals: reducing infant and maternal mortality…

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

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



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]

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 -- some times 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.

Resources

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

Next steps

Dec. 8, 2022, 9:00 a.m. – noon

AHEI Virtual Showcase

The virtual showcase is an opportunity to share successes and learn from peers. Participating facilities will highlight the work they have done throughout the year to improve the collection of patient demographic data, build or strengthen community relationships and identify and address healthcare disparities.

ADVANCING HEALTHCARE
EXCELLENCE AND INCLUSION

Questions?

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