Building Community Partnerships

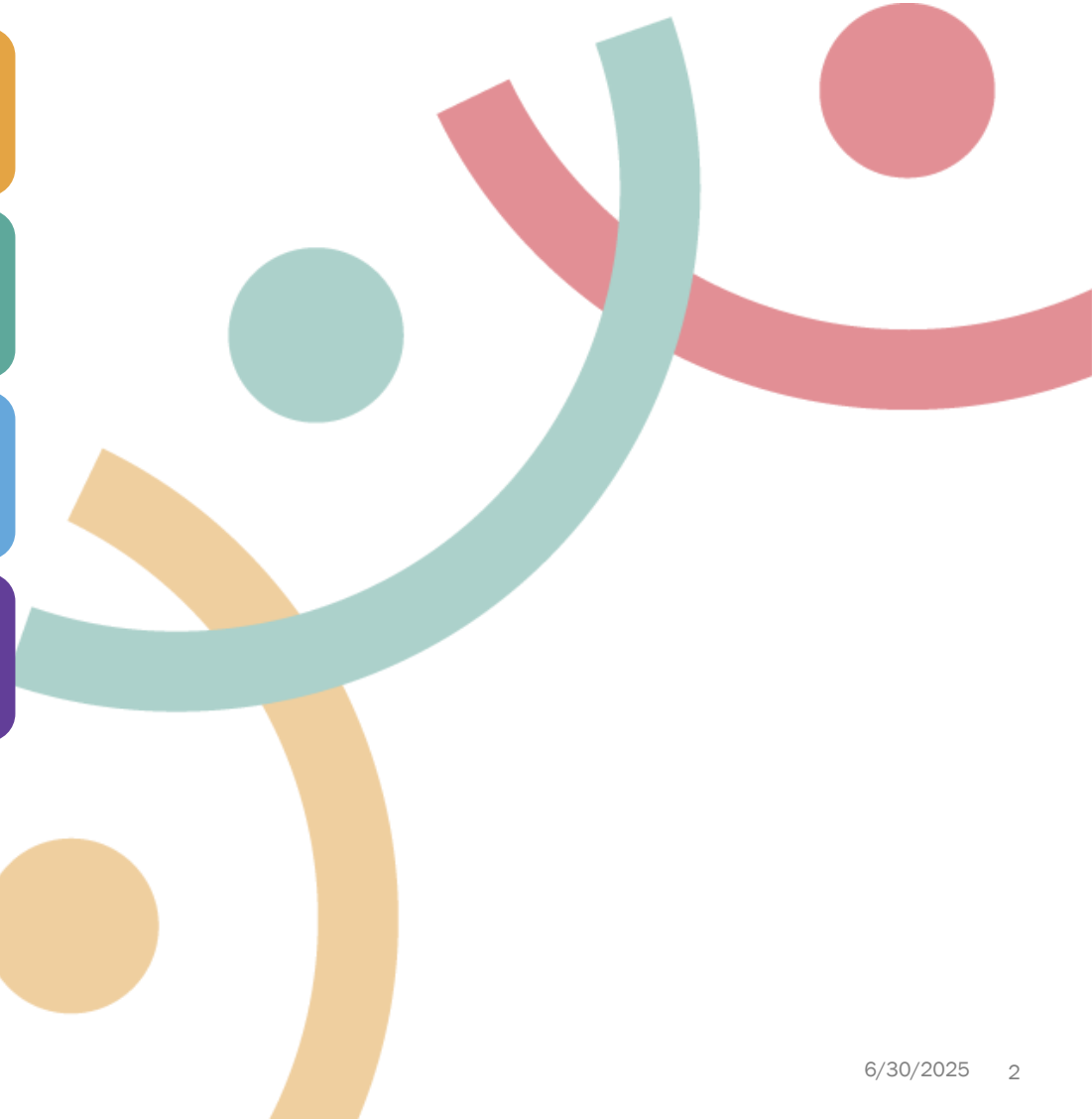
Theresa Green PhD, MBA, Public Health Sciences

Center for Community Health & Prevention

University of Rochester Medical Center

Agenda

- Introductions
- Our partners
- Session 8: Building Community Partnerships
- Questions & Answers



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Our partners

Mother Cabrini HEALTH FOUNDATION

DataGen® Insights for Healthcare®

OUR FUNDER

Funding from the Mother Cabrini Health Foundation allows HANYS to expand its capacity to provide education, direct support, tools and data to our members. With Care Connections, we strive to build hospital-community partnerships and share evidence-based chronic disease prevention and management strategies to address healthcare access barriers at the local level.

OUR PARTNER

DataGen®, Inc. develops custom analytics for participants to help them understand healthcare access barriers and the chronic disease burden in their communities so they can develop tailored interventions.

Today’s presenter

Theresa Green, PhD, MBA

Center for Community Health & Prevention

University of Rochester Medical Center

Building Community Partnerships

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University of Rochester Medical Center

Care Connection Virtual Learning Series
July 1, 2025

Anesthesiologist Assistant
for 20 years
MS in Anesthesiology

Community Health Planner for
7 years
PhD in Interdisciplinary Health
Sciences (WMU)

MBA in Health Care Administration

URMC - Education

- Teach medical, nursing and graduate students about population health, health systems and community health
- Partner with 20+ community agencies and community driven initiatives for student active learning experiences
- Director for the URMC Public Health Grand Rounds that engage speakers locally and nationally for continuous medical education
- Lead the Health Equity Education task force to support resident education in health equity

URMC - Policy

- Lead the Monroe County Community Health Improvement Planning for 4 hospitals/health department (CHNA/CHIP)
- President of the Monroe County Board of Health

What is partnership? (community engagement)

Community engagement

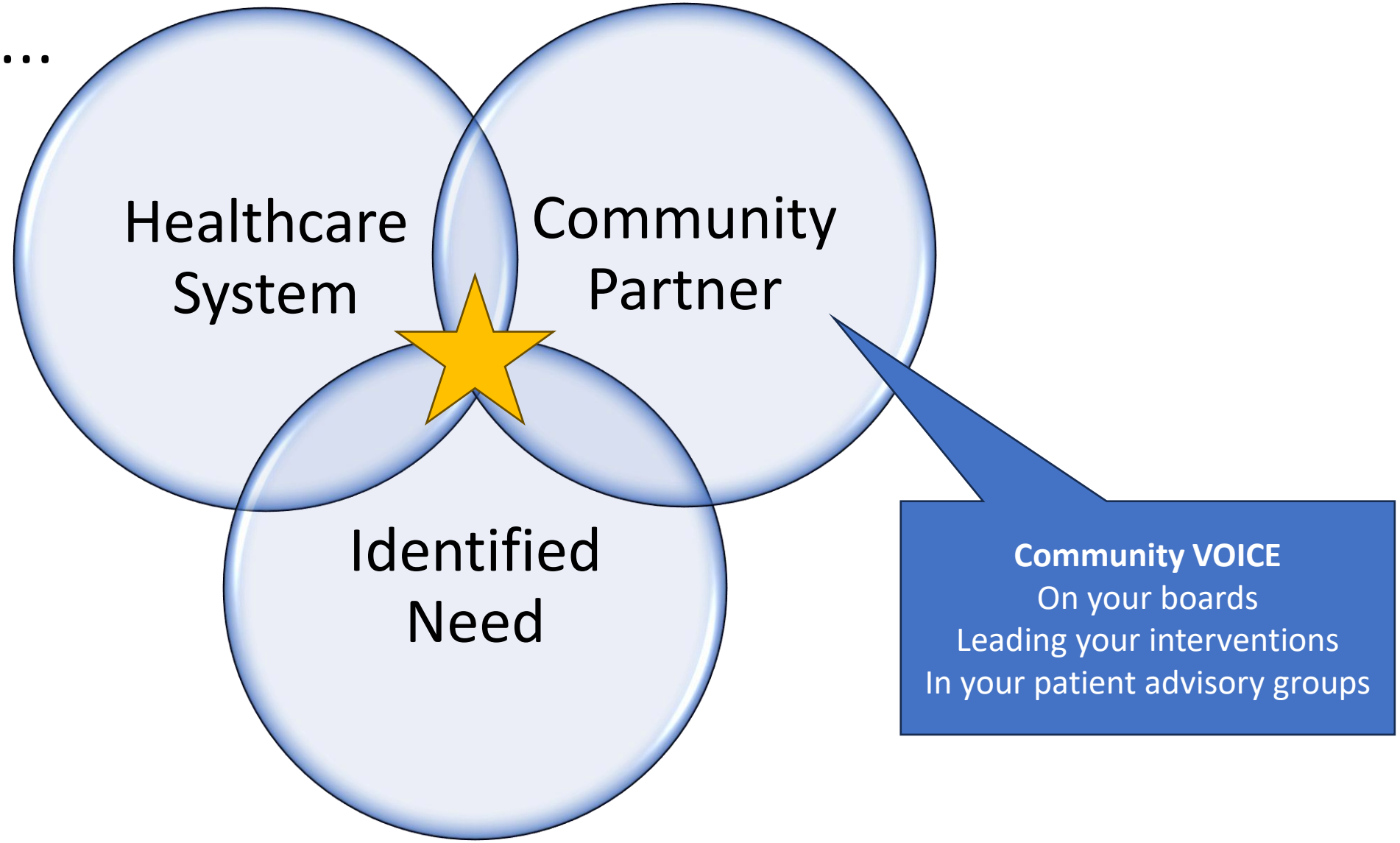
defined as collaboration between institutions and the larger communities (local, regional/state, national, global)

Goal!

for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity.

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

In all we do…



…as a system or a program

The WHY…

- Hospital mission: improve the health of (members of) the communities they serve
- Largest driver of health: social circumstance + behaviors

Hospitals are ideally positioned to improve health; but to improve health hospitals need to align their organizational efforts and partner with communities

Upstream

Downstream

Social Inequities

Class
Race/Ethnicity
Immigration Status
Gender
Sexual Orientation

Institutional Inequities

Policies, Programs, and Practices in:

Government agencies
Schools
Laws and Regulations
Non-Profits
Businesses

Living Conditions

Physical Environment:
Land use
Transportation
Housing
Exposures

Economic Environment:
Employment
Income
Retail businesses
Occupational risk

Service Environment:
Health care
Education
Social Services

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

Behaviors

Smoking
Nutrition
Physical activity
Sexual behavior
Drugs and alcohol

Health Outcomes

Chronic disease
Communicable disease
Injury
Mortality
Life expectancy

In COMMUNITY

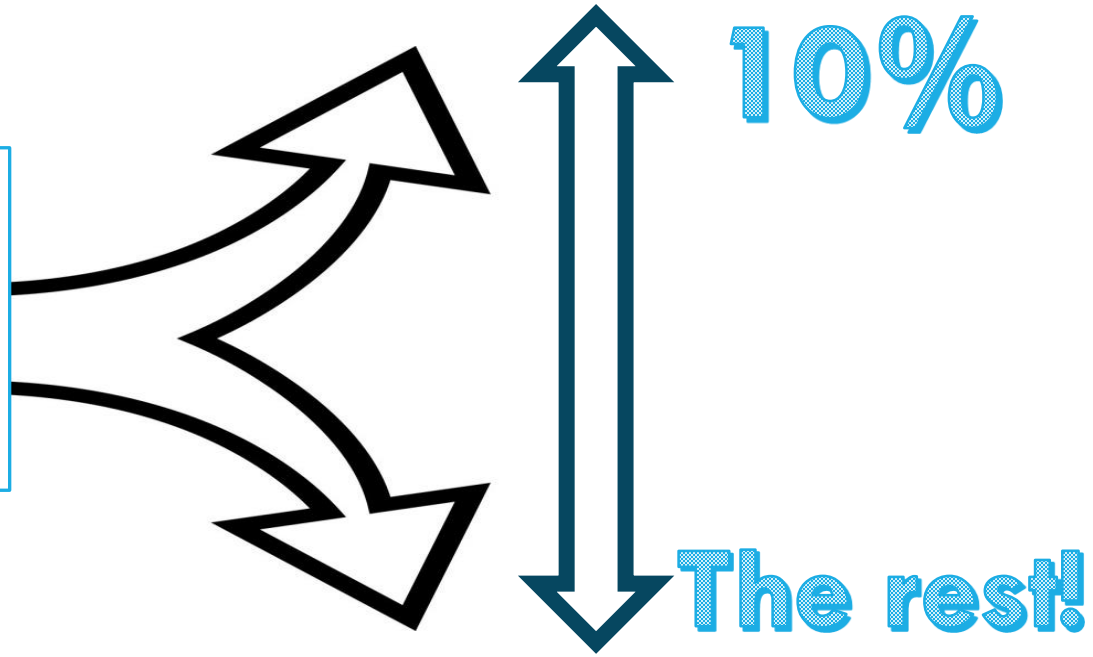
In Health Systems

HEALTH VS HEALTH CARE

QUALITY HEALTH CARE = hospitals, health care systems, clinics and other places where care is provided. Primarily interested in treating disease and illness, screening, treatment

Diabetes
Asthma
Heart Disease
COPD
Mental Health
Cancer

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



HEALTH outside of HEALTH CARE = social, economic, education, and/or environmental systems that keep us healthy. Social systems, public health,

Community partnership is critical for improved health outcomes, increased health equity and for the long-term success and sustainability of any intervention

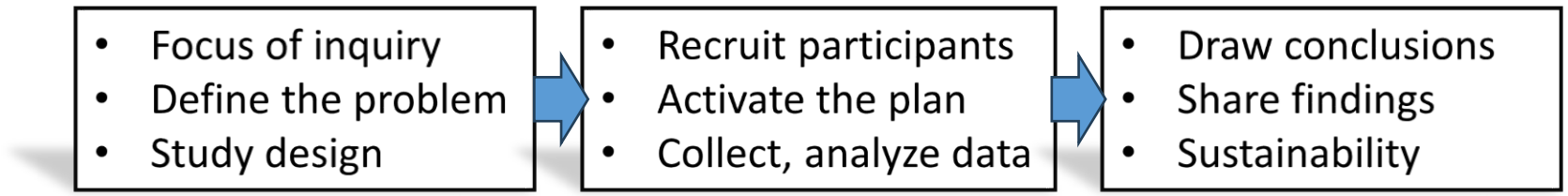
Community

KEEPS PROJECT RESPECTFUL, ACCESSIBLE, AND SOCIALLY RELEVANT

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

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

Understandable messaging
Ownership to build sustainability
Assures conclusions are palpable



Infrastructure
Evidence Base for Interventions
Experience with funders and reporting

IRB for safe recruitment
Scientifically appropriate work
Academic rigor and processes

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

KEEPS PROJECT SCIENTIFICALLY SOUND AND ACADEMICALLY RELEVANT

Health Systems/Academics

Community Partnership Roadmap

1.
IDENTIFY AND ENGAGE PARTNERS

2.
DEFINE GOALS AND ROLES

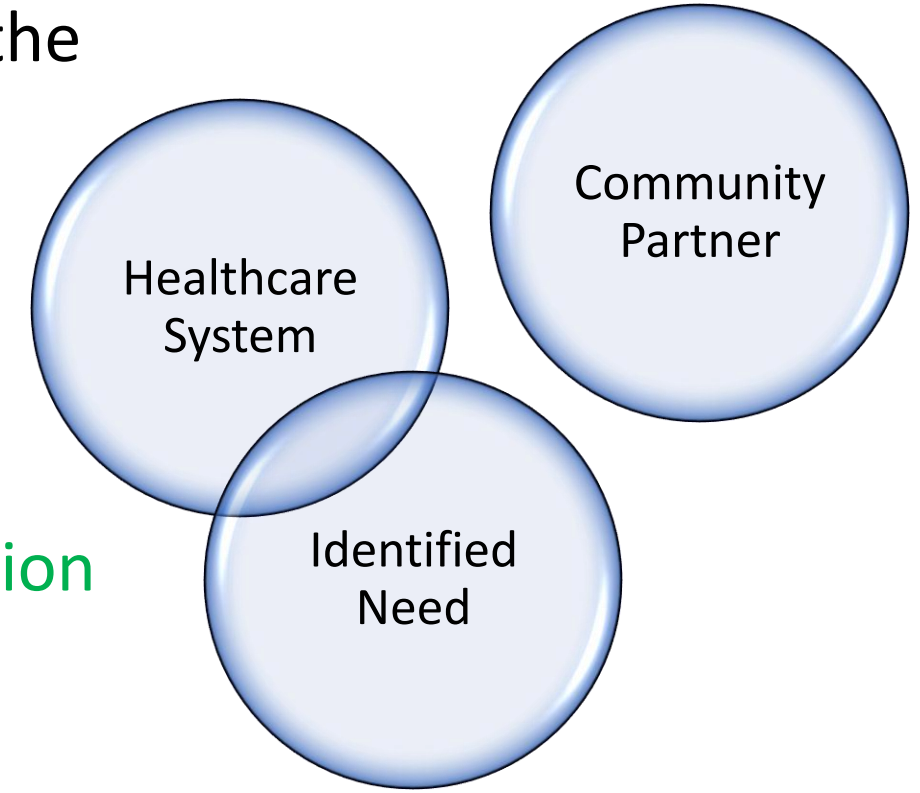
3.
IMPLEMENT AND EVALUATE

4.
SUSTAIN PARTNERSHIP

Seeking community partners

1.
IDENTIFY AND ENGAGE PARTNERS

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



MEET WITH YOUR PARTNER

Competency/Capacity Matrix

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

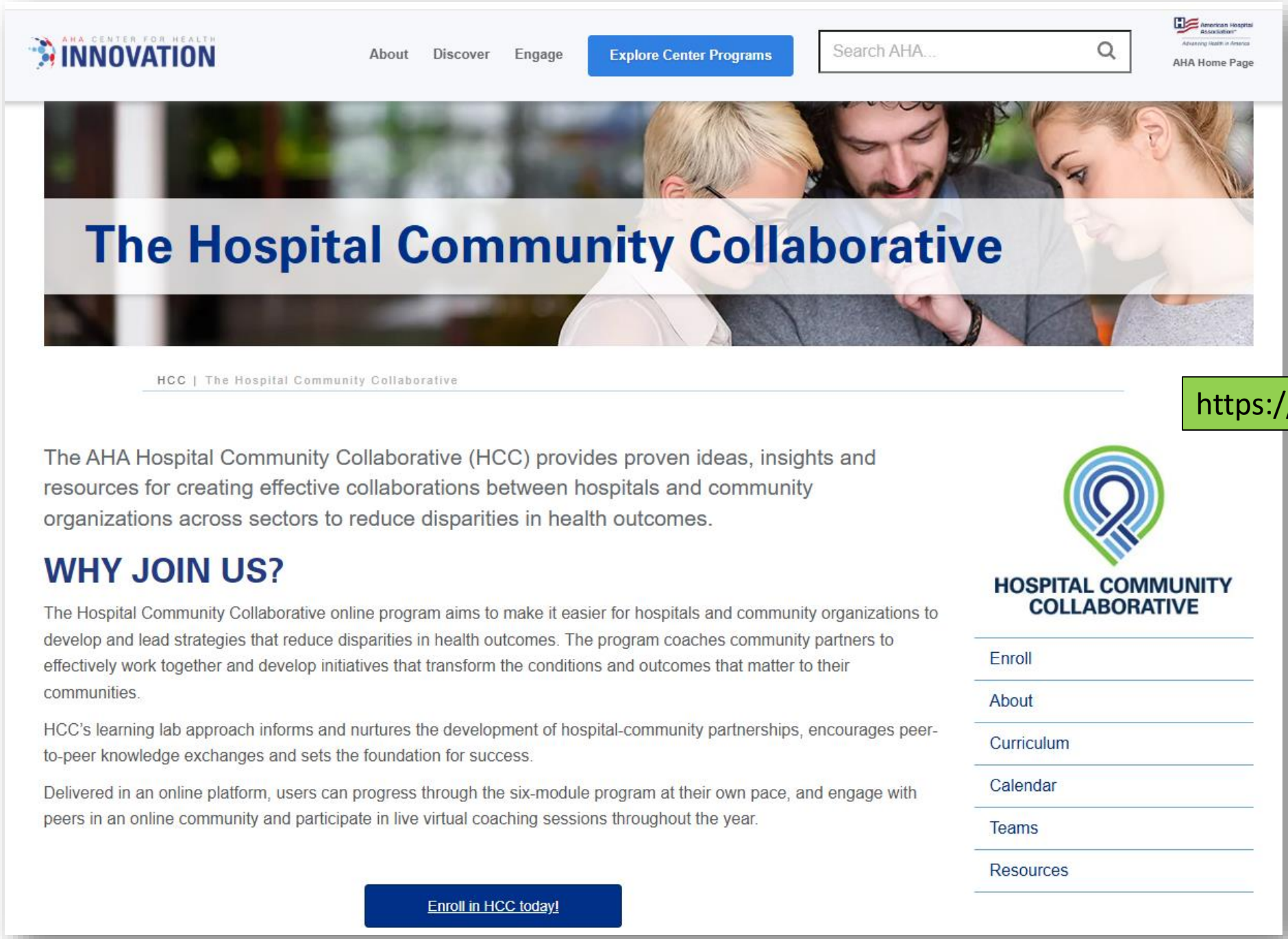
Sample Partnership Capacities

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

Who is needed to make this successful?

HOSPITAL COMMUNITY COLLABORATIVE

Empowering Partnerships for Health Equity



https://www.aha.org/center/hcc

Where is the community expertise for needed competencies?

- Ask the community!

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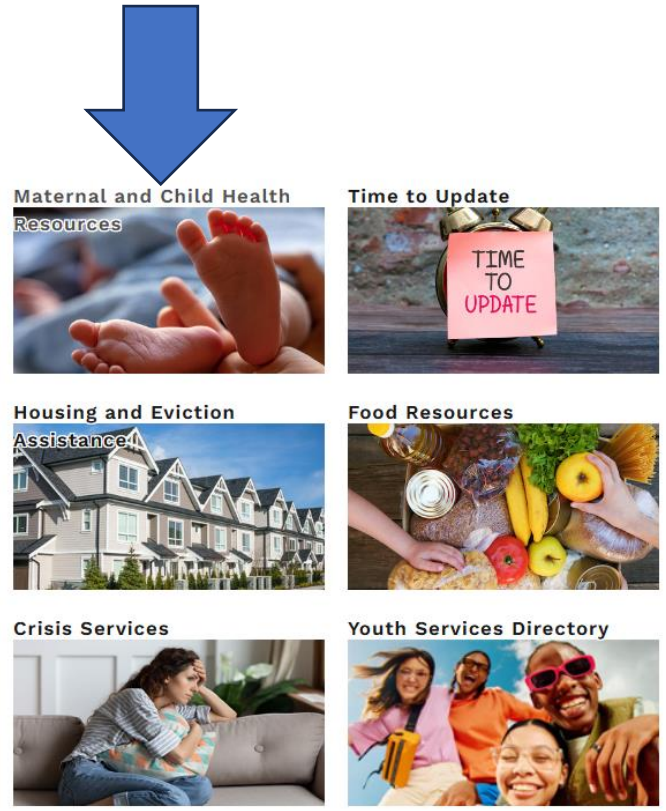


- Explore community coalitions
- Check community resources
- Ask community members – community advisory groups
- Ask the local public health department
- Review CHNA/CHIP
- Don't assume there is an existing coalition!

Be creative in identifying partners – Look for assets!

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

Great resource!! With examples

Plan for engagement of external partners - You have options!

2.
DEFINE GOALS AND ROLES

Add a partner to the internal team

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

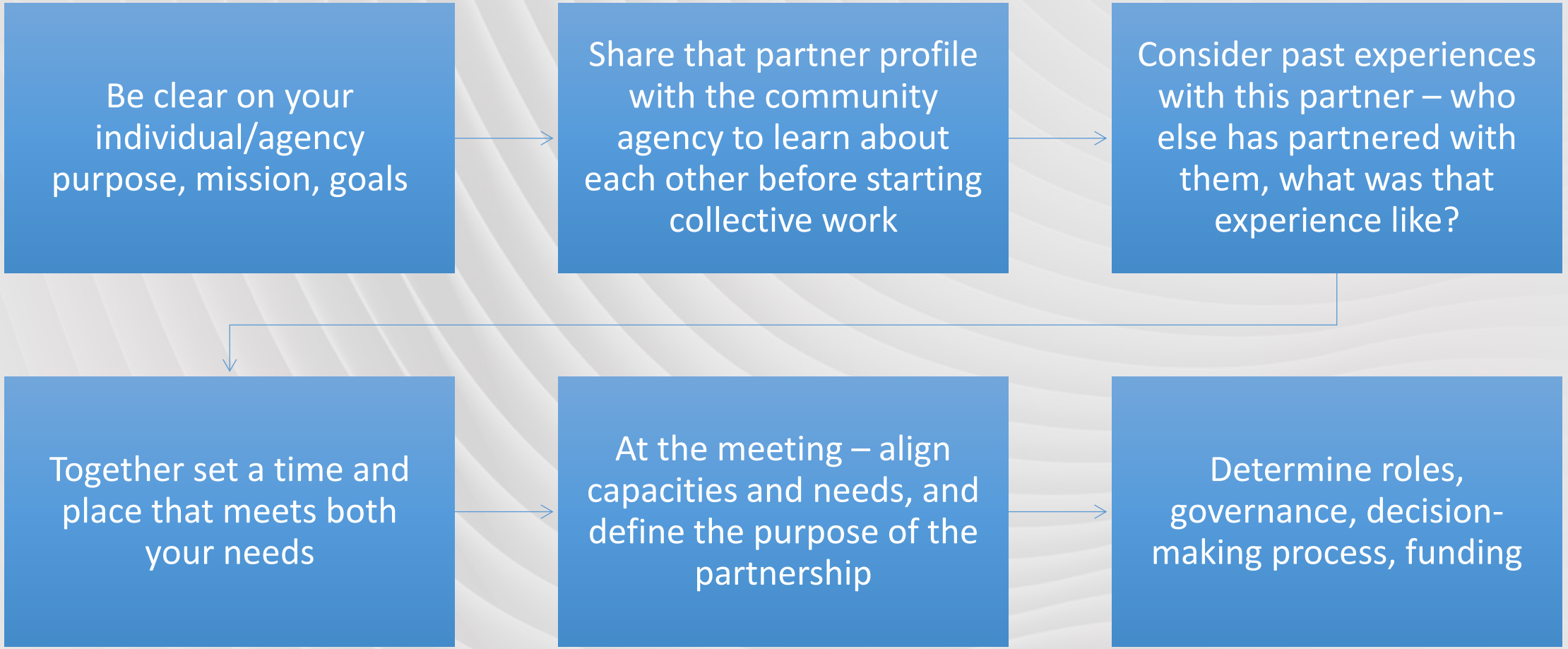
Join an existing coalition

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

Create a new coalition

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

Get to know your partner



GET STARTED

15-MINUTE ACTIVITY

Develop Your Partner Profile

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

WHOM DO YOU SERVE?

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

WHAT DO YOU DO?

- Purpose?
- Timeframe?

WHY DO YOU DO IT?

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

HOW DO YOU DO IT?

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

WHAT ARE THE UNIQUE CONTRIBUTIONS YOU BRING TO THIS PARTNERSHIP?

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

WHY ARE YOU PURSUING THIS PARTNERSHIP?

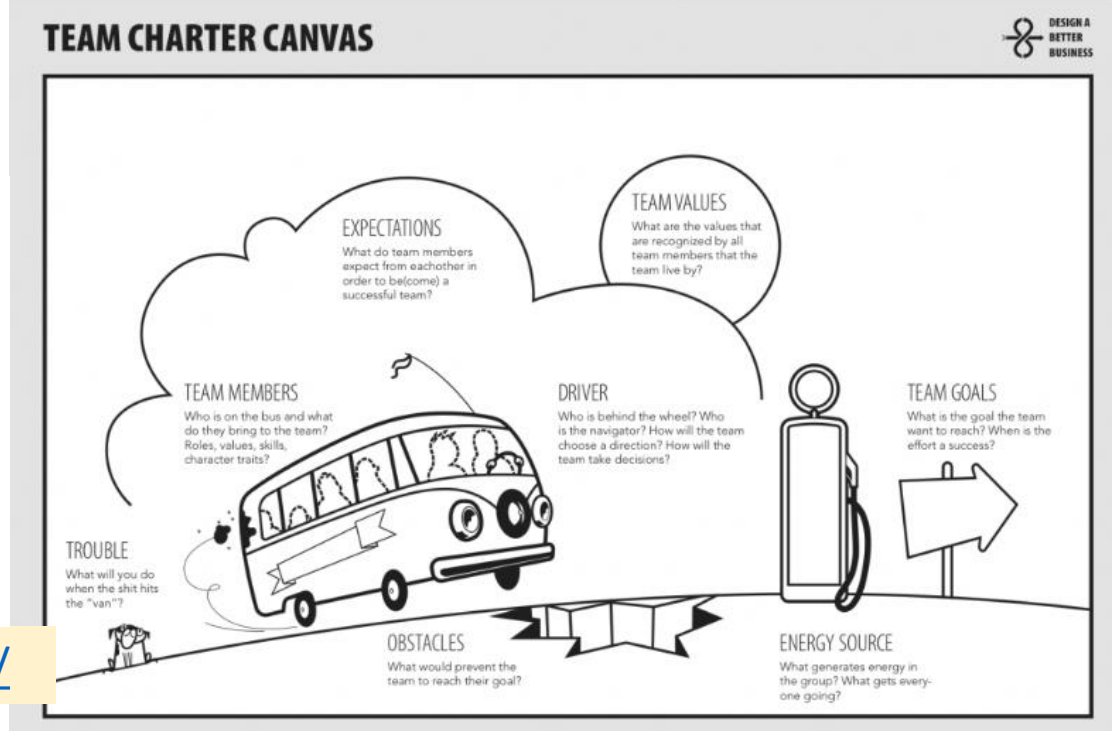
- What need are you fulfilling?
- How do you know this is a need?
- How does this partnership goal support your organization's strategic priorities?
- What are the revenue/funding opportunities that factor into this partnership?

HOSPITAL COMMUNITY COLLABORATIVE
Empowering Partnerships for Health Equity

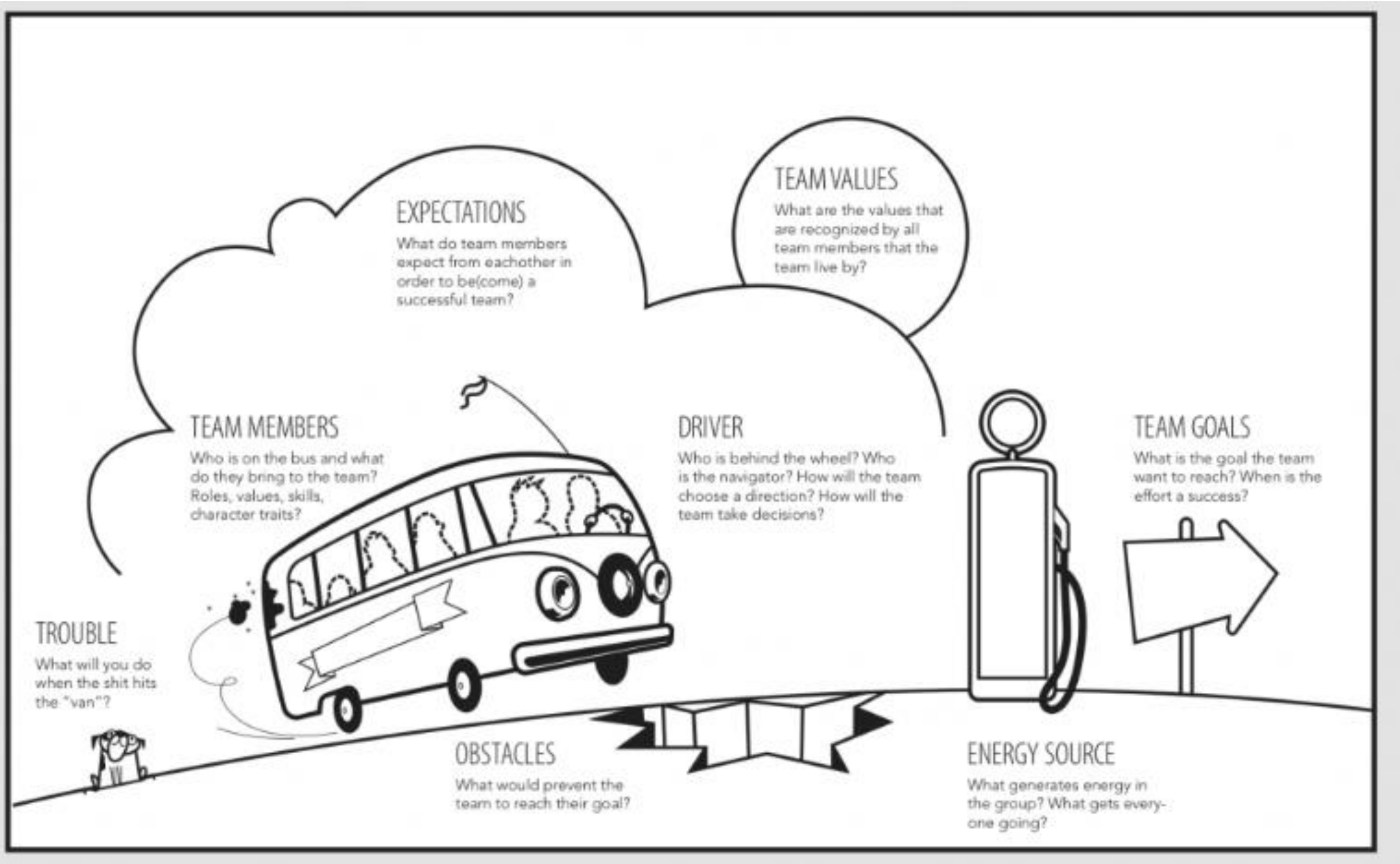
To help assure achievability of shared goals

Develop a **TEAM CHARTER**

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



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

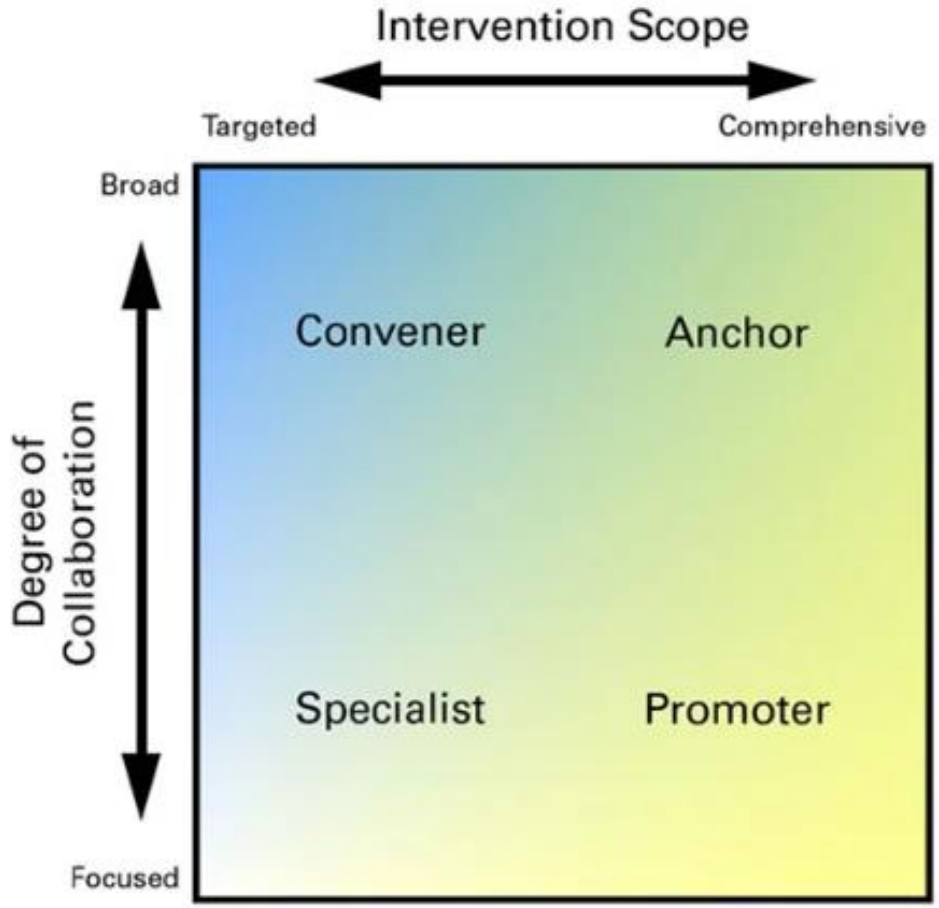

EXPECTATIONS
What do team members expect from eachother in order to be(come) a successful team?
TEAM VALUES
What are the values that are recognized by all team members that the team live by?
TEAM MEMBERS
Who is on the bus and what do they bring to the team? Roles, values, skills, character traits?
DRIVER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

Principles of Partnership

- **Community driven:** Engage a diverse group in your community that strives to address a problem common to all.
- **Achieve more together:** Leverage each partner's complementary talents and resources to create synergy among partners that accomplishes more.
- **Meaningful engagement:** Include representation by all community stakeholders in determining, planning and executing priorities.
- **Partner equity:** All stakeholders are considered equal, regardless of size or financial or in-kind contributions to the partnership.
- **Shared purpose:** As stewards of the community's resources, partners are committed to working collaboratively for the benefit of the community.
- **Best practices and innovation:** Community health is complex, involving multiple social needs. Best practices and innovative approaches are required.
- **Systems approach:** A systems approach can better create a foundation for integrated community delivery systems.
- **Goals and progress reports:** Change requires focusing on results. Measures or indicators of progress and communication to the community offer direction, inspiration and motivation. Monitoring demonstrates partner accountability, earns community trust and builds hope.
- **Governance structure:** Sustainable governance structure is dependent on a clear purpose, partner commitment, a plan of action, adequate funding, effective implementation and demonstrated progress.

Adapted from "Learnings on Governance from Partnerships that Improve Community Health: Lessons Learned from Recipients of the Foster G. McGaw Prize for Excellence in Community Service," Center for Healthcare Governance, American Hospital Association, 2016.

Hospital Roles in Building Community Partnerships



» **Specialist:** Concentrates on a few specific issues

» **Promoter:** Supports other organizations' initiatives

» **Convener:** Brings together hospital and community stakeholders

» **Anchor:** Leads initiatives to build a Culture of Health

Source: Creating Effective Hospital-Community Partnerships to Build a Culture of Health," Health Research & Educational Trust/American Hospital Association, 2016.

IAP2 Spectrum of Public Participation

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

INCREASING IMPACT ON THE DECISION

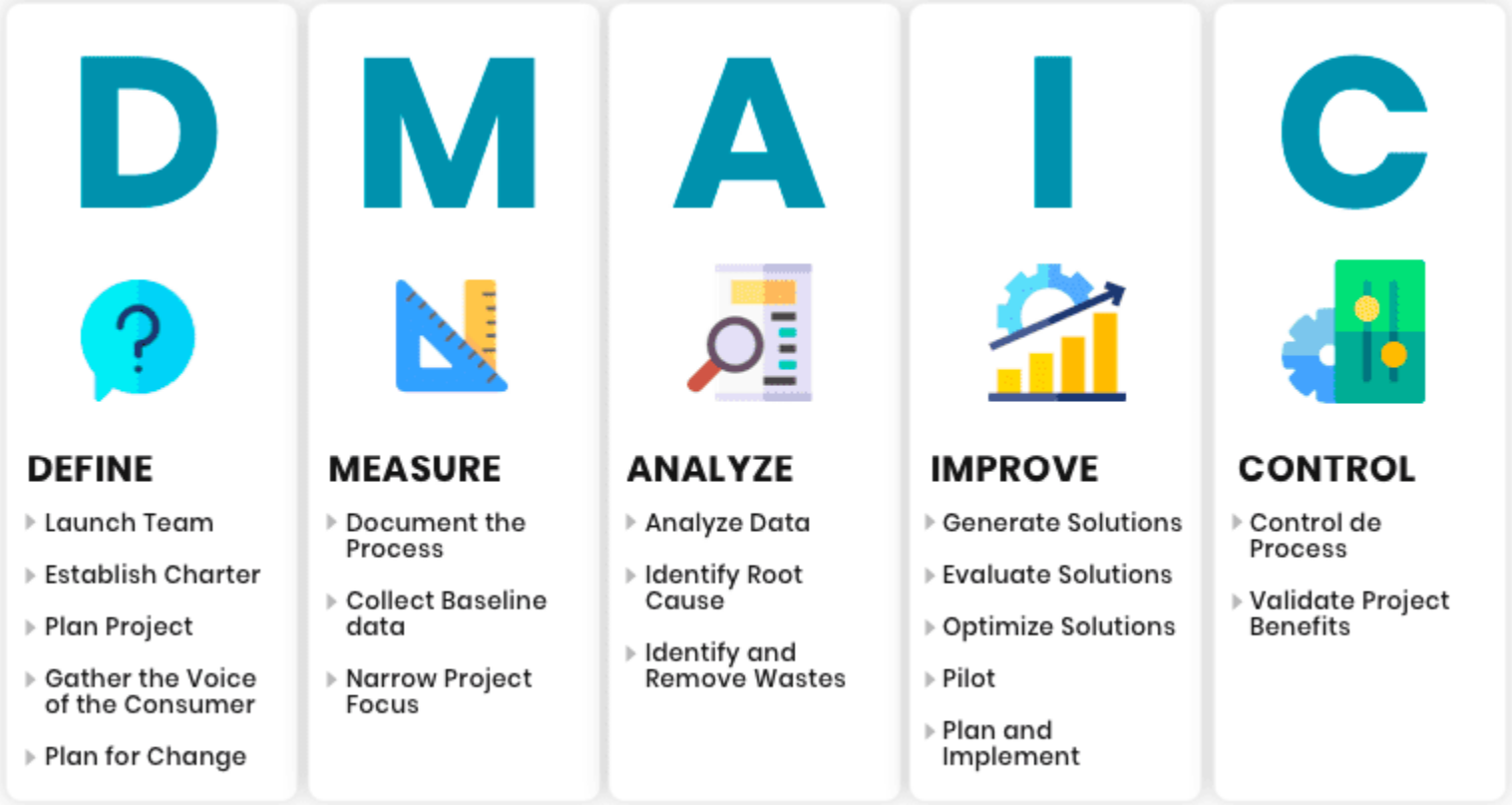
	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly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

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

DMAIC Framework

3.
IMPLEMENT AND EVALUATE

Data-driven, systematic approach to process improvement



DEFINE the problem

- Identify opportunities
- Identify key contributors/stakeholders
- Consider a charter with a community-based organization

EQUITY CONSIDERATIONS

- Consider the needs and issues faced by populations experiencing the worst health outcomes
- What populations are impacted most by the problem you have identified
- Does the team composition and structure promote inclusivity?
- How will the patient voice by incorporated into the program design?

How can you incorporate ‘community voice’ into your QI project?

MEASURE

- Document the current process
- Collect baseline data and define where you want to go
  - Develop a SMARTIE Aim
  - Define metrics and measures

EQUITY CONSIDERATIONS

- What inequities already exist?
- Examine the data by race, gender, economic status, geography, etc.
- Are the targeted populations clearly articulated in the aim statement?
- What strategies will help mitigate bias in data collection or analysis
- What is the local culture surrounding the issue?

Develop SMARTIE Goals

Goals are critical to success! To improve diversity, equity and inclusion, we must be intentional in our efforts. Use this worksheet to craft SMARTIE goals!

SMARTIE Framework by the Management Center
http://www.managementcenter.org/resources/smartie-goals-worksheet

SPECIFIC	MEASURABLE	ACTION-ORIENTED	RELEVANT	TIME-BOUND	INCLUSIVE	EQUITABLE
What is it you want to achieve? Consider including the 5Ws: what, why, who, where and when.	How will you know when you have achieved your goal? To be able to track progress and to measure the result of your goal, consider: how much or how many?	To keep you motivated toward attaining your goal, are there identifiable intermediate actions/milestones? *Variations: achievable, attainable, acceptable.*	What results can realistically be achieved given your available resources, including people, knowledge, money and time? *Variation: realistic*	What is an appropriate deadline for achieving your goal? How will you track progress?	How will you include traditionally marginalized people into processes, activities, and decision making in a way that shares power.	How will you include an element of fairness or justice that seeks to address systemic injustice, inequity, or oppression.

INCLUSIVE: How will you include traditionally marginalized people into processes, activities, and decision making in a way that shares power

EQUITABLE: How will you include an element of fairness or justice that seeks to address systemic injustice, inequity or oppression

Population Health Data Resources

SCOPE	Name	WEBSITE
National Level	Healthy People 2030	https://health.gov/healthypeople
State Level (NY)	NYS Prevention Agenda	https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/
County Level	County Health Rankings	https://www.countyhealthrankings.org/
County Level (NY)	NYS Prevention Agenda	https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/
Regional (Finger Lakes)	Common Ground Health	https://www.commongroundhealth.org/
Monroe County Specific	MC Dept of Public Health	https://www2.monroecounty.gov/health-index.php
City Level	City Health Dashboards	https://www.cityhealthdashboard.com/
Rochester Specific	RocHealthData	https://rochealthdata.org/
	ACT Rochester	https://www.actrochester.org/

Publish data from survey and EMR in a user-friendly reports

Non-Health Data: US Census Bureau

- Survey every 10 years (2020) and estimates in between
- www.census.gov
- https://www.census.gov/quickfacts/rochestercitynewyork
- Try others that use the census data + other big data sources
  - https://www.zip-codes.com/
  - American Community Survey

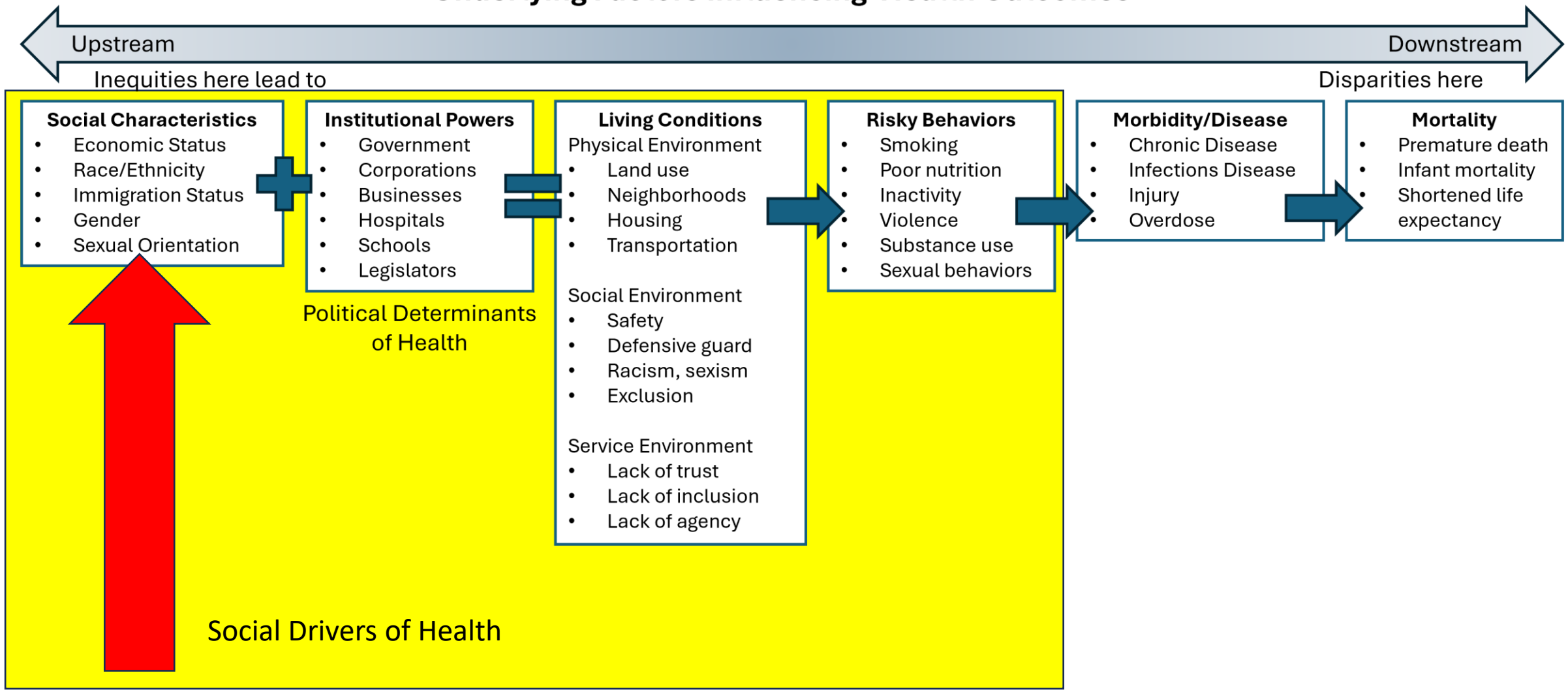
ANALYZE

- Get at the ROOT CAUSE of the problem
- Examine the problem and consider underlying drivers

EQUITY CONSIDERATIONS

- How can we address the root cause of the outcome disparity
- How can we ensure that those impacted by the intervention will have input into the process

Underlying Factors Influencing Health Outcomes



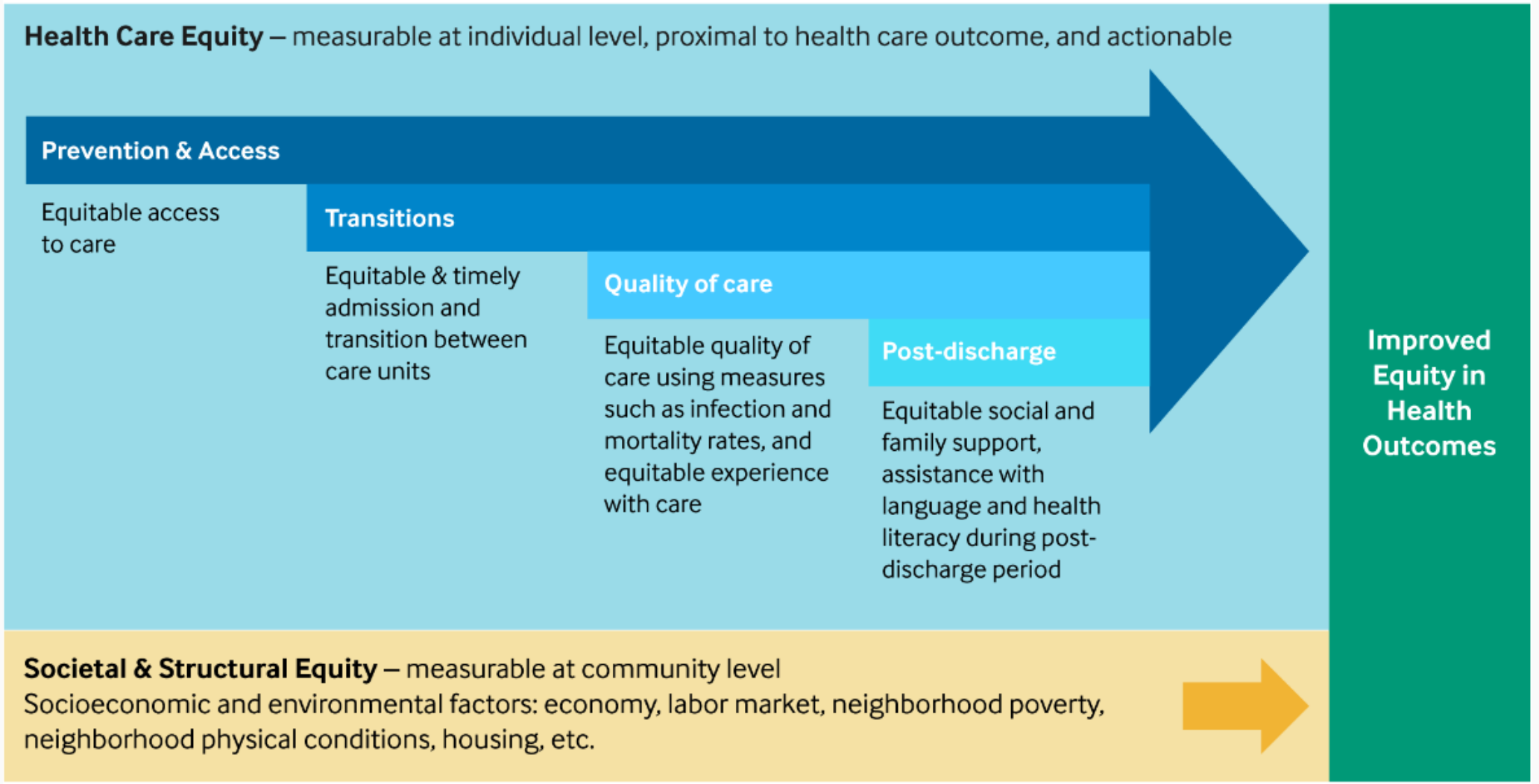
IMPROVE

- Have a clear vision of what your “ideal state” would be and work to get there
- Consider evidence-informed interventions that address each (or a specific) key driver/root cause
- Start with a pilot (PDSA cycles)

EQUITY CONSIDERATIONS

- Will the change impact those most vulnerable?
- Is the community voice considered when establishing the “ideal state”?
- Are materials readily available in the languages and formats necessary?

A Conceptual Model for Health and Health Care Equity



Sai Ma, PhD, et al. Distinguishing Health Equity and Health Care Equity: a Framework for Measurement. **NEJM Catalyst March 7, 2023**

Improving health outcomes…

There are many approaches, but some of the most effective are:

- POLICY improvements
  - A law, regulation, procedure, administrative action, incentive, or voluntary practice of government and other institutions.

- SYSTEMS improvements
  - Change that impacts all elements, including social norms of an organization, institution, system or community

CONTROL

- Monitor and stabilize the process improvement
- Find ways to replicate and disseminate findings

EQUITY CONSIDERATIONS

- Were there any inadvertent intervention-generated disparities created?
- Do the target populations believe the project outcomes?
- Are results shared with stratified data that shows gains were experienced equally by all?
- How can we share the results among all stakeholders?
- How do we sustain equitable change?

Sustainability

4.
SUSTAIN
PARTNERSHIP

Sustainability Factors to consider:

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

HOSPITAL COMMUNITY COLLABORATIVE
Empowering Partnerships for Health Equity

HOSPITAL COMMUNITY COLLABORATIVE

Empowering Partnerships for Health Equity

PARTNER PLEDGE

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

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

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

Signature

Name, Organization 1

Signature

Name, Organization 2

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

Sustainability

New York State Health Foundation Sustainability Toolkit

Suggests choosing 3-4 factors to sustain a project

APPENDIX A

SUSTAINABILITY FACTORS:
DEFINITIONS AND EXAMPLES

SUSTAINABILITY DEFINITION:

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

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

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

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

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

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

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

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

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

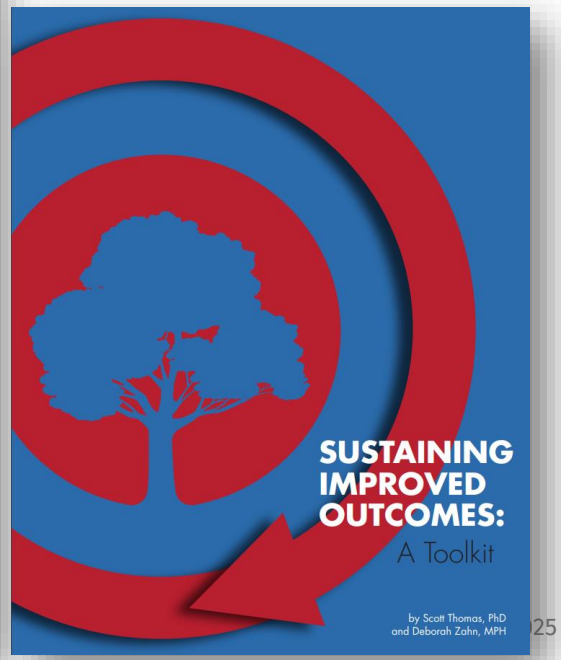
PARTNERS – involvement of partners who actively support new ways of working and improved outcomes. Examples include partners who continue to contribute staff or resources after the implementation phase.

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

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

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

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



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]

Be TRUSTWORTHY

AAMC | Center For Health Justice

Home News Our Work Get Involved Resources Career Development About Us

Home / Trustworthiness / The Principles of Trustworthiness

MENU

AAMC Center For Health Justice

The Principles of Trustworthiness Toolkit

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

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

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

The Principles of Trustworthiness

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

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

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

10 Principals of Trustworthiness

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

HANYS
Always There for Healthcare
SINCE 1925

Quality | Collaboratives | Clinical & Operational Oversight | Business Services | Advocacy & Analysis | Education

Care Connections:

- Care Connections Home
- Virtual Learning
- Faculty and Staff
- Partners
- CHW Scholarship
- Community Partner Stipend
- Resources
- Join Us

Care Connections Resources

- Care Connections Program One-pager
- Partnership Building Toolkit

Our Organization

About HANYS
Award Programs
Membership
Member Directory

Advocacy & Analysis

Analyses
Behavioral Health

Care Connections

Partnership building toolkit

This toolkit includes a step-by-step guide to coalition building, partnership building activities and advocacy information. Use these tools to help your team define your impact area, establish partnerships, set shared priorities and sustain your efforts.

Pulling it all together… an example

Community Health

Needs Assessment and Improvement Plan

Theresa Green, PhD, MBA
Associate Professor, Public Health Sciences
Associate Director, Center for Community Health & Prevention
Director Health Equity Education

NEW YORK STATE OF OPPORTUNITY. Department of Health

"HDs and hospitals are **strongly encouraged to develop one assessment and one plan per county by working together** with other partners in their region. This collaborative approach will leverage the efforts and resources of all health organizations in a community toward shared community health goals and improve effectiveness and reduce duplication in the assessment and planning effort."

Monroe County
Community Health Improvement Workgroup

chiw

Started 2000

UR MEDICINE
Strong Memorial Hospital
Highland Hospital

ROCHESTER REGIONAL HEALTH
Rochester General Hospital
Unity Hospital

Monroe County Department of Public Health

+ **Community Input**

Meet our team

CHIW Reporting CORE Member Organizations	Representatives	Leadership
Monroe County Department of Public Health	Kathy Carelock	Marielena Vélez de Brown, Commissioner
University of Rochester Medical Center Strong Memorial Hospital	Mardy Sandler Wendy Parisi Kelly Luther	David Linehan, CEO URMC Kathy Parrinello, CEO
University of Rochester Medical Center Highland Hospital	Kara Halstead Kim Foster	Kathy Parrinello, CEO Maura Snyder, COO
Rochester Regional Health – Rochester General Hospital & Unity Hospital	Katie Sienk Dawn Davison	Mary Parlet, SVP CAO Ambulatory Care
Coordinated by the Center for Community Health & Prevention	Theresa Green Kim Chiaramonte	Edith Williams, Director

CHIW Partner Advising Member Organizations

- Monroe County Office of Mental Health
- Monroe County Medical Society
- Common Ground Health
- Rochester RHIO
- FLPPS
- ABC
- Jordan Health
- City of Rochester
- United Way
- AA and Latino Health Coalitions
- Trillium Health
- Ronald McDonald House

chiw | MONROE COUNTY
COMMUNITY HEALTH IMPROVEMENT WORKGROUP

Our Mission

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

Community Health Needs Assessment (CHA)
and
Community Health Improvement Plan (CHIP)

Authorizing body of the hospital facility must:

1. Adopt a **Community Health Needs Assessment** Report
   - Describe the community (Monroe County)
   - Assess the health needs of the community (Monroe County)
   - Engage the community and public health experts
   - Share broadly

CHA

2. Adopt **Implementation Strategy** for the identified needs
   - How does the hospital plan to address the priority needs
   - Prioritization process and why not address the other high needs

CHIP

IRS ...every 3 years to maintain tax-exempt status

Process for CHNA/CHIP for Monroe County

Create the Monroe County 2025 Collaborative **Community Health Needs Assessment**

Select 3 top priorities in line with the NYS Prevention Agenda Objectives

Create the Monroe County 2025-2027 Collaborative **Community Health Improvement Plan**

Commit to Evidence-informed interventions and metrics

Approved by hospital boards

then **IMPLEMENTATION!**

New York PA for 2025-2030

NEW YORK STATE | Department of Health

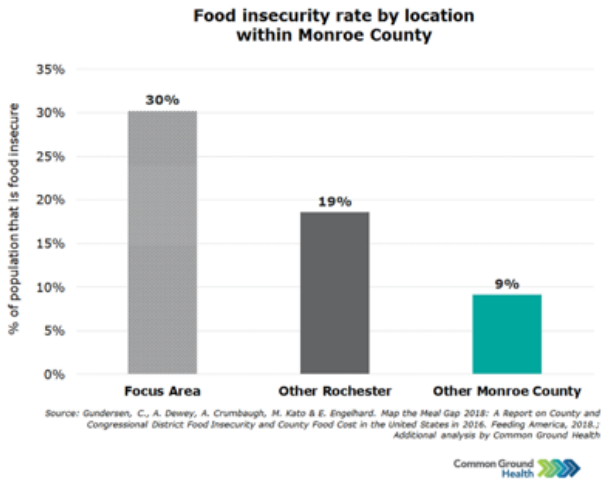
HP2030

Domain	Overarching Goal
Economic Stability	All people in New York have the financial security and support needed to thrive
Social and Community Context	All people in New York live in communities that foster and support optimal physical, mental, and social well-being
Neighborhood and Built Environment	All people in New York have equitable access to healthy, and safe neighborhoods
Health Care Access and Quality	All people in New York have access to timely, affordable, and high-quality health care services
Education Access and Quality	All people in New York have equitable access to quality education in an environment that supports physical and mental health

2025 Community Health Needs Assessment

participation in food assistance programs and broader societal-level improvements in economic stability[6].

The rate of food insecurity in Monroe County in 2022 was 12.1% representing approximately 91,000 residents. An older assessment of food insecurity showed the disparity between high risk areas of the City, Rochester as a whole, and the rest of Monroe County.



Source: Gundersen, C., A. Dewey, A. Crumbaugh, M. Kato & E. Engelhard. Map the Meal Gap 2018: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States in 2016. Feeding America, 2018.; Additional analysis by Common Ground Health

The Children's Agenda, a community-based organization in Monroe County that advocates for children, recently conducted a countywide survey of 600 Monroe County parents in December 2023. The survey found most families earning less than $100K cannot afford fruits and vegetables weekly. In addition, 41% of those earning between $50K and $100K were rationing food so that their family doesn't run out. Sadly, among families earning less than $50K, 58% rely on food pantries and 50% of parents skipped meals so that their children could eat.

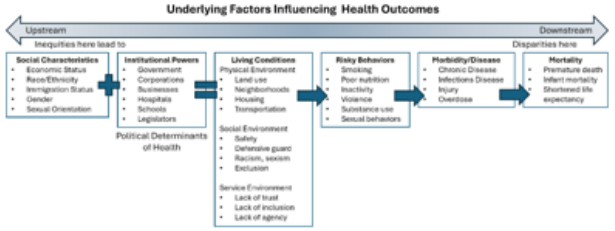
[6] https://map.feedingamerica.org/county/2022/overall/new-york/county/monroe

2. Monroe County Health Status

Health Status description: Provide an overview of the population's health and identify factors that contribute to health status and health challenges.

Health Status Description: There are many health challenges in Monroe County, similar to the health challenges for the Finger Lakes region, the state of New York, and the country. Importantly, most health status metrics are the result of unhealthy behaviors influenced by non-optimal environments. In the fall/winter of 2024 and early spring of 2025, a review of existing health data was conducted to identify priority areas of concern for the health of Monroe County.

Although the data reviewed will focus on downstream, end-state mortality and morbidity measures, a model of the underlying root causes of those health outcomes is important to keep in mind.



Adapted from the Bay Area Regional Health Inequities Initiative: http://www.barhii.org

Several social characteristics and living conditions were described in the previous Community Description section of this report. For the Health Status Description section, we will describe risky behaviors, morbidity and disease, and mortality metrics for Monroe County.

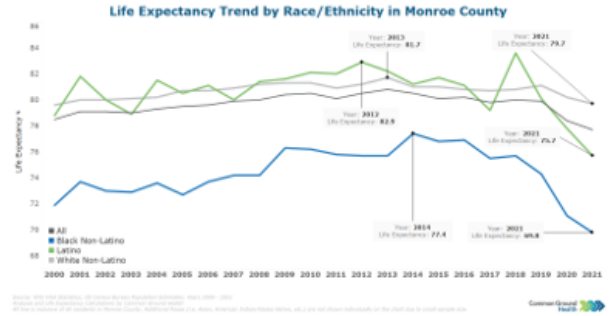
Mortality

The most downstream result of all demographics, political and social drivers of health is mortality or the measures of life expectancy. The CDC National Center for Health Statistics defines life expectancy as the average number of years of life remaining to a person at a particular age and based on a given set of age-specific death rates.

Live expectancy has been calculated for the Finger Lakes Region, and Monroe County, based on the most recent data (2021). The Monroe County life expectancy reached a high of 80.8 in 2013, followed by a plateau and then decline with COVID. Monroe County life expectancy in 2021 was 77.7 years, in line with the life expectancy for NY State excluding NY City, which was 78.1 years. Common Ground Health recently wrote a Spotlight report titled: The Decline in Life Expectancy in the Finger Lakes Region, 2013-2021 to further explore these trends and reasons for them.

There are many disparities, or differenced, in life expectancy based on gender, geography, race and socio-economic status. Importantly, geographic location is closely tied to race as well as income and poverty. As already mentioned, due to redlining and other racist policies and practices, the city of Rochester is plagued with high poverty rates, and much lower incomes that the surrounding suburbs. In addition, most of the residents of Monroe County who identify as Black or Latino live in the city of Rochester.

Life expectancy by race shows that those identifying as Black have a life expectancy of 69.8 years, a full 10 years less than that for those identifying as White (79.7 years).



Life expectancy by zip code shows similar disparities. Residents in some Rochester zip codes have a life expectancy of 71.1 years which is 13.7 years shorter than a zip code in nearby Pittsford (84.8 years), a town with much more resources.

Extensive review of data!

Community Engagement

- Self-Reported Health Concerns in the Finger Lake Region (2022) from Common Ground Health
- URMC Community Advisory Council (CAC) Meeting 7-23-2024
- URMC Patient and Family Advisory Council Groups (PFAC)
- African American Health Coalition, Latino Health Coalition and Indigenous Health Coalition meeting 9.26.24
- Rochester Flower City AmeriCorps Members 10.25.24
- Monroe County Dept of Public Health Board of Health 11.4.24
- Hospital leadership from Strong, Highland, Rochester General/Unity

What does the community want?

Priorities from Community Engagement with Data Support

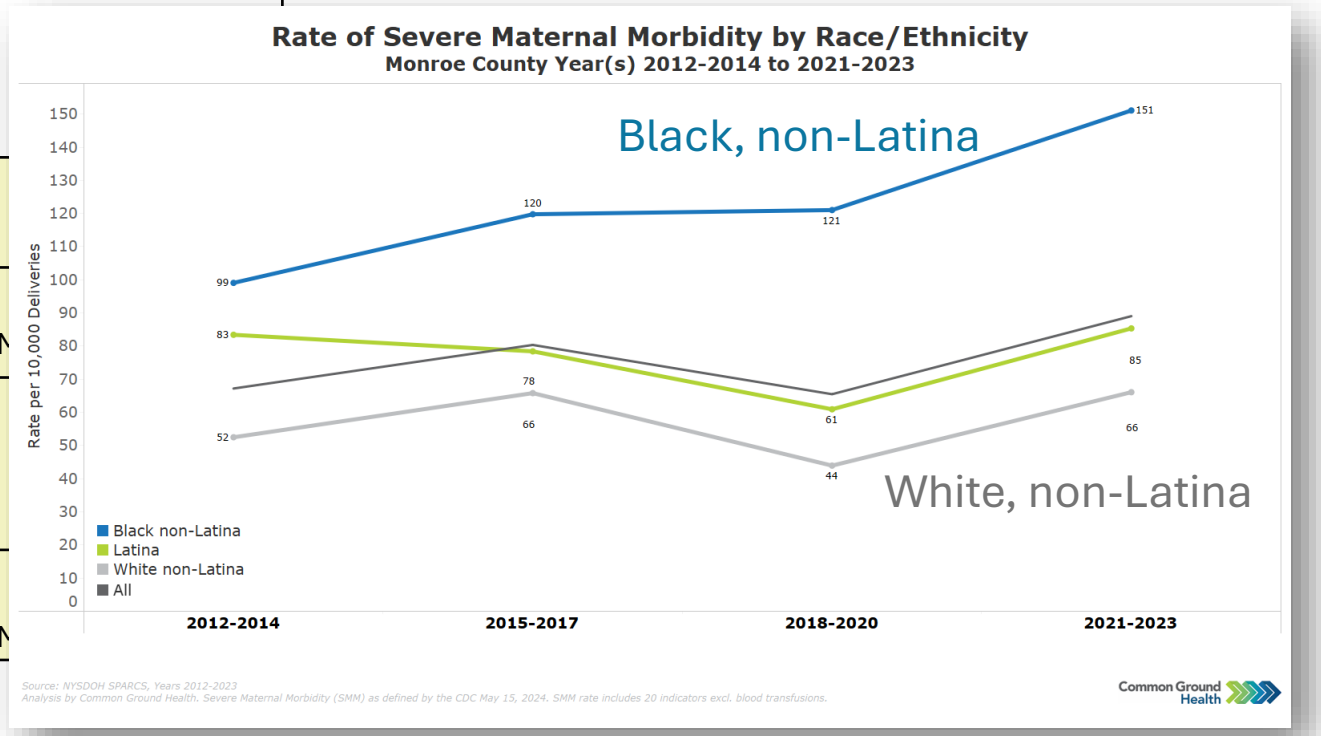
Vision	**Every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan**
Foundations	**Health Equity** **Prevention Across the Lifespan** **Health Across All Policies** **Local Collaboration-Building**

Domain	Priorities
Economic Stability	**Economic Wellbeing** ❑ **Poverty** ❑ **Unemployment** ❑ **Nutrition Security** ❑ **Housing Stability and Affordability**
Social and Community Context	**Mental Wellbeing and Substance Use** ❑ **Anxiety and Stress** ❑ **Suicide** ❑ **Depression** ❑ **Drug Misuse and Overdose Including Primary Prevention** ❑ **Tobacco/ E-cigarette Use** ❑ **Alcohol Use** ❑ **Adverse Childhood Experiences** ❑ **Healthy Eating**
Neighborhood and Built Environment	**Safe and Healthy Communities** ❑ **Opportunities For Active Transportation and Physical Activity** ❑ **Access to Community Services and Support** ❑ **Injuries and Violence**
Health Care Access and Quality	**Health Insurance Coverage and Access to Care** ❑ **Access to and Use of Prenatal Care** ❑ **Prevention of Infant and Maternal Mortality** ❑ **Preventive Services for Chronic Disease Prevention and Control** ❑ **Oral Health Care** (e.g., routine preventive care, community water fluoridation, dental sealants, and access to dental services for Medicaid covered population) **Healthy Children** ❑ **Preventive Services** (e.g.; immunization, hearing screening and follow up, and lead screening) ❑ **Early Intervention** ❑ **Childhood Behavioral Health**
Education Access and Quality	**PreK-12 Student Success And Educational Attainment** ❑ **Health and Wellness Promoting Schools** (e.g.; timely immunization, healthy school meals, social emotional learning, and counselling and mentoring including avoidance risky substances) ❑ **Opportunities for Continued Education** (e.g.; high school completion programs, transitional and vocational programs, literacy initiatives, and reskilling and retraining programs)

Healthcare Access and Quality

Prevention of Infant and Maternal Mortality

New York State Prevention Agenda Dashboard: Maternal and Infant Health				
Metric	**Monroe**	**Trending**	**PA24 Goal**	**Comparison**
Percentage of women who report ever talking with a health care provider about ways to prepare for a healthy pregnancy, aged 18-44 years	30.2	No change	38.1	
Maternal mortality, rate per 100,000 live births	30.2	Worse	16	
Infant mortality, rate per 1,000 live births	4	No change	4	
• Infant mortality per 1,00 live births among those who identify as Black or African American (2019-2021)	13.3			
Percentage of births that are preterm	10.8	No change	8.3	



The rate of severe maternal morbidity (not dying but seriously poor outcomes from delivery) has increased for mothers who are Black, non-Latina from a rate of 99/10,000 deliveries in the 2012-14 time-period to a rate of 151/10,000 deliveries in the 2021-2023 time-period. This is much worse than the trend for all deliveries in Monroe County where the maternal morbidity rate increased from 52 to 66 per 10,000 during the same time-period.

“How does the hospital plan to address the need?”

Identified Need	Plan for Evidence-Based Interventions	Community Partners
POVERTY 1. Reduce the percentage of people living in poverty in Monroe County from the baseline of 13.1%, with special attention to Rochester residents.	• Educational programs that enhance recruitment for needed positions while mitigating disparities in recruitment efforts • Engage in multi-sector collaborations that highlight the health burden of unemployment and under-employment • Screen for SDH and connect patients to resources through (1115) Social Care Networks, food pantries, etc.	• FLPPS Workforce Investment Organization (WIO) • ABC • RMAPI • City, AmeriCorps
ANXIETY AND STRESS 2. Decrease the percentage of adults in Monroe County who experience frequent mental distress from 15.6%.	• Promote evidence-based mindfulness resources to reduce the negative impact of stress and trauma • Social prescribing: Connecting individuals with local community resources and activities that address their social needs and promote well-being	• Office of Mental Health • Community gardens, music, art
BLACK MATERNAL MORTALITY 3. Decrease the rate of maternal mortality among Black, non-Hispanic birthing persons. Monroe County Maternal Mortality is 26.5 per 100,000 Live Births. Black severe maternal morbidity is almost 3 times worse than the overall	• Implement community-based Doula programs - Establish policies and practices to support doula care and services • Connect birthing people at high risk to evidence-based or evidence-informed home visitation programs • Integrate hospital-based midwifery model of care • Collect and stratify clinical data by race, ethnicity, and language (REAL) data to analyze and identify drivers of inequity and targets for quality improvement.	• Healthy Baby Network • FLPPS MCH Planning Program • MCH-Advisory Group • ROC Family TeleConnect

Maternal Child Health - Advisory Group

Maternal and Child Health Advisory Group (MCH-AG) is a strong interdisciplinary network of over 120 providers, community members, advocates and Doulas. Established in 2019, we host quarterly meetings.

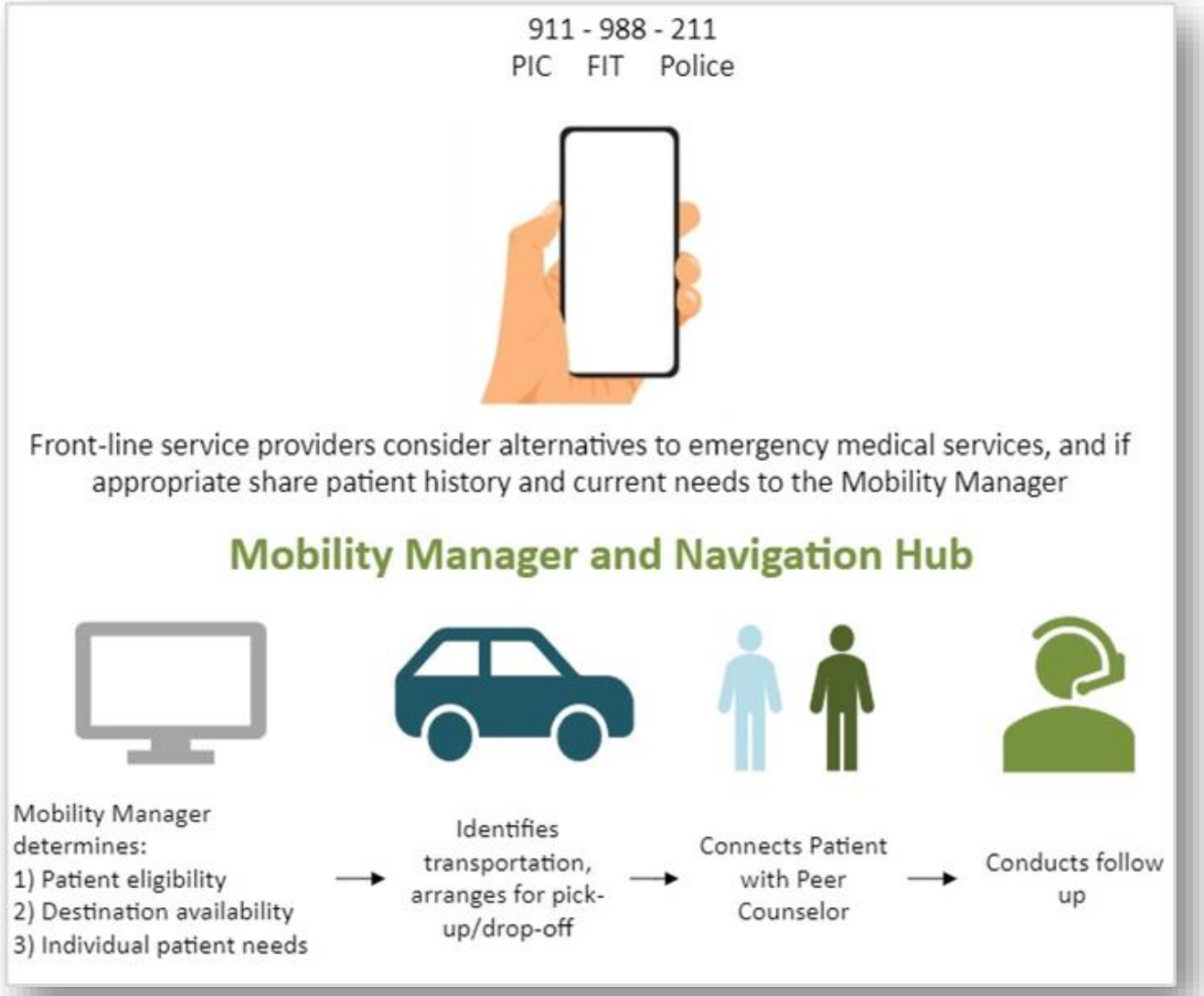
- 3-4 presentations each meeting
  - Opportunity to present new ideas (Irth, Doula READI, Peer Breastfeeding)
- Interdisciplinary discussion improves understanding of barriers, needs and wins
  - Opportunity to learn and celebrate progress
- Advocacy efforts
  - Senator Samra Brouk presented on maternal mental health
  - Doula reimbursement, IPP LARC reimbursement
- Increase presence
  - Community baby shower contributions
  - Perinatal network forum advisement
  - Share community events
  - Community advisory board for ROC Family Teleconnect

"It is a great cross-sectional table. It's vitally important for health systems to be connected to CBOs"

"I have learned so much in this group … I really enjoy making connections and knowing more about the resources in the area"

Behavioral Health Crisis Navigation Hub

- Synergy meeting held with over 60 experts in the field of behavioral and mental health, substance use disorders and clinical care focused on transportation for these services
- Developed a Transportation Planning Team
- Support from hospital systems, EMS, 911, 211/988, Dept. of Public Health, Office of Mental Health
- Created a pilot proposal to coordinate behavioral health resources and the transportation to them, to avoid EMS and Emergency Department visit when not necessary
- Given to Office of Mental Health for Sustainability, RFP out May 2025

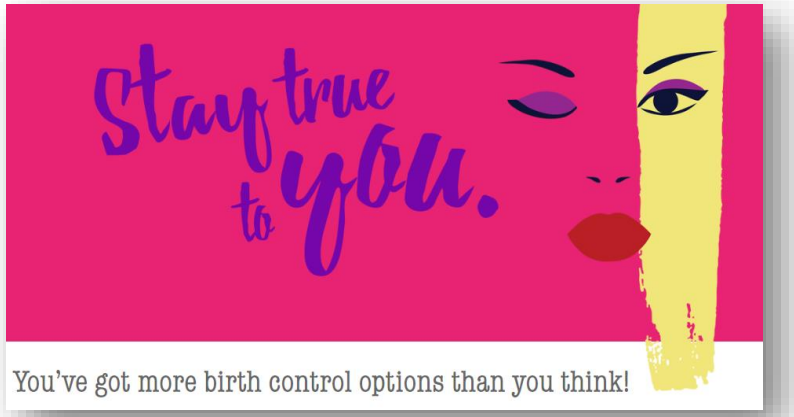


CHIW Mini Grant Projects FY23

Focus 1: Addressing Disparities in Maternal and Child Health

Metro Council for Teen Potential addressed disparities in maternal and child health through relaunching a media campaign that supported the reproductive justice and autonomy of young women for the prevention of unintended pregnancy in the City of Rochester.

The campaign had 2 million impressions and more than 7,500 visits to the website in summer 2023!



Focus 2: Promoting Mental Health and Well-Being

Five courses were held, with 61 individuals attending full training; with 45 becoming certified in MHFA!

Wellness Associates of Greater Rochester Mental Health First Aid—an internationally recognized program designed to increase awareness of the signs and symptoms of mental illness and decrease negative stigmas associated with these conditions.

CHIW Mini Grant Project FY24

Focus 2: Promoting Mental Health and Well-Being

Rochester Refugee Resettlement Services (RRRS) is a small community-based organization that helps New Americans become self-sufficient and successful community members.

They own 85 homes in the Rochester area, and house more than 500 people. The goal of this project is to screen refugee children for behavioral health conditions through a CDC Mental Health screening, developed specifically for pediatric patients.

Completed 98+ screens of children for mental health, on-track for 215 children by grant end.

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UNIVERSITY of ROCHESTER MEDICAL CENTER

Care Connections

Questions?

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