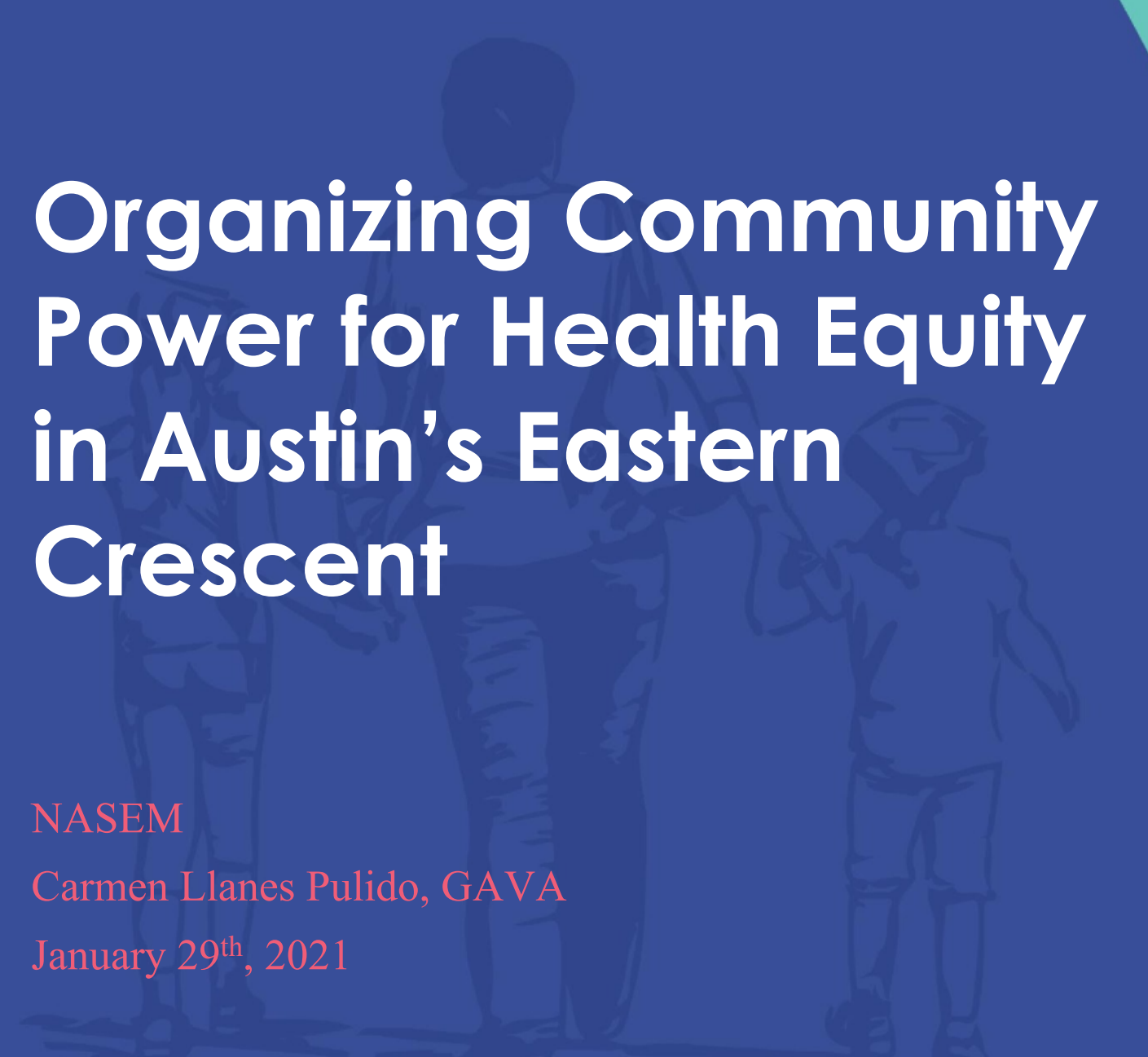


sankofa

The logo for Sankofa features the word "sankofa" in a bold, orange, sans-serif font. The letter "o" is replaced by a green circular emblem containing a stylized white bird with its head turned back, perched on a green branch with two leaves.

Community Development Corporation

Building healthier communities for generations to come



Organizing Community Power for Health Equity in Austin's Eastern Crescent

NASEM

Carmen Llanes Pulido, GAVA

January 29th, 2021

GAVA
GO! AUSTIN/VAMOS! AUSTIN

Who We Are & What We Do

Mission **GAVA organizes and mobilizes community power for health equity:** We reduce barriers to health while increasing institutional capacity to respond to the people most impacted by historic inequities.

Vision We envision a future in which a person's neighborhood, income, race, ethnicity, primary language, and/or immigration status no longer serve as predictors of health outcomes.

We seek to address systemic health inequities in the following ways:

- **Increase access to physical activity and improved nutrition**
- **Build community power**
- **Foster permanency**

Our case statement in more detail

Increase access to physical activity and improved nutrition

- Organize to build partnerships that provide healthy programming
- Organize to connect neighborhood leaders to resources
- Organize for a healthier built environment that supports improved nutrition and active lives

Build community power

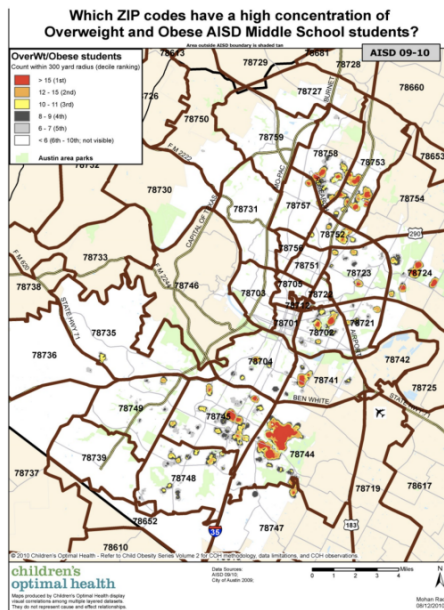
- Provide training, resources and support to develop strong community leaders
- Engage them civically to change the programs, policies, and processes that impact their communities' health
- Develop new and existing networks of community leaders and groups to address health inequities

Foster permanency

- Identify specific policies, tools, and programs that can mitigate cost of living and pressures from climate change that worsen displacement
- Build coalitions with other groups impacted by displacement and/or working toward solutions
- Foster partnerships and initiatives that support residents' economic mobility and opportunities to increase their incomes.

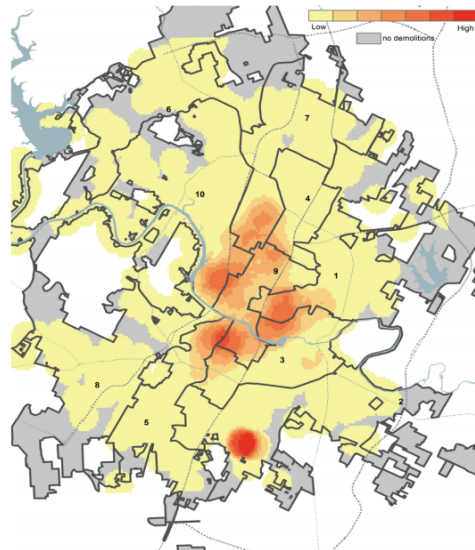
What's the scale, strategies and core impact of your work?

GAVA is focused in three areas of Austin (Southeast, South and North-Central), where rates of chronic disease and childhood obesity are highest.



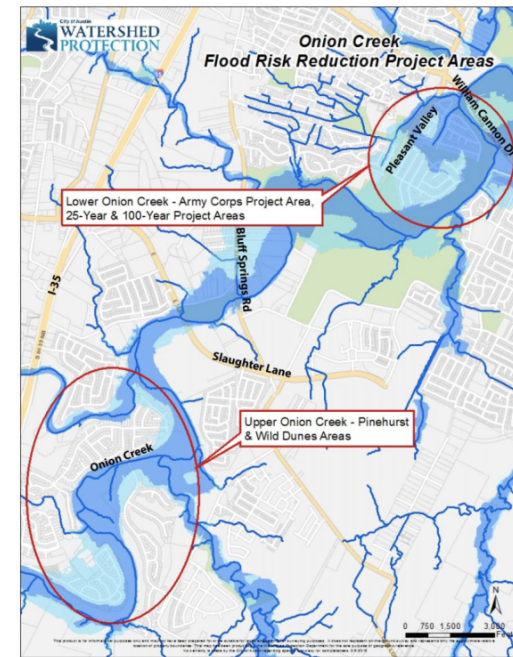
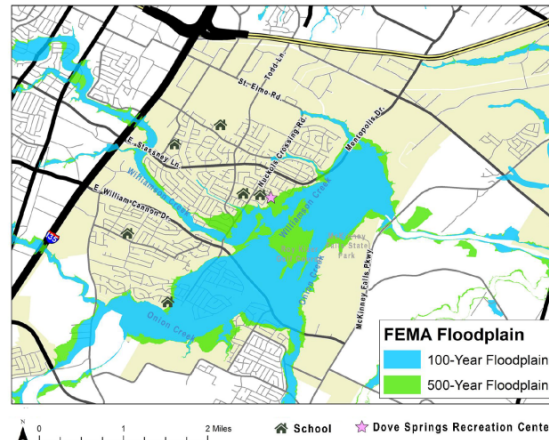
A map created by Children's Optimal Health overseeing which zip codes had a high concentration of overweight/obesity among middle school students. (Source: <http://www.cohtx.org/>)

Appendix A - Density Map of Property Locations for Approved Demolition Permits, FY08 to FY16



Watershed

Onion Creek has an area of 344 square miles and its lower downstream portion runs through southeast Austin. The lower Onion Creek area is currently the City's highest priority for flood hazard mitigation. Williamson Creek's lower portion also runs through the southern edge of Dove Springs. Encroachment and alteration of natural waterways has resulted in eroding stream banks and threatened property.

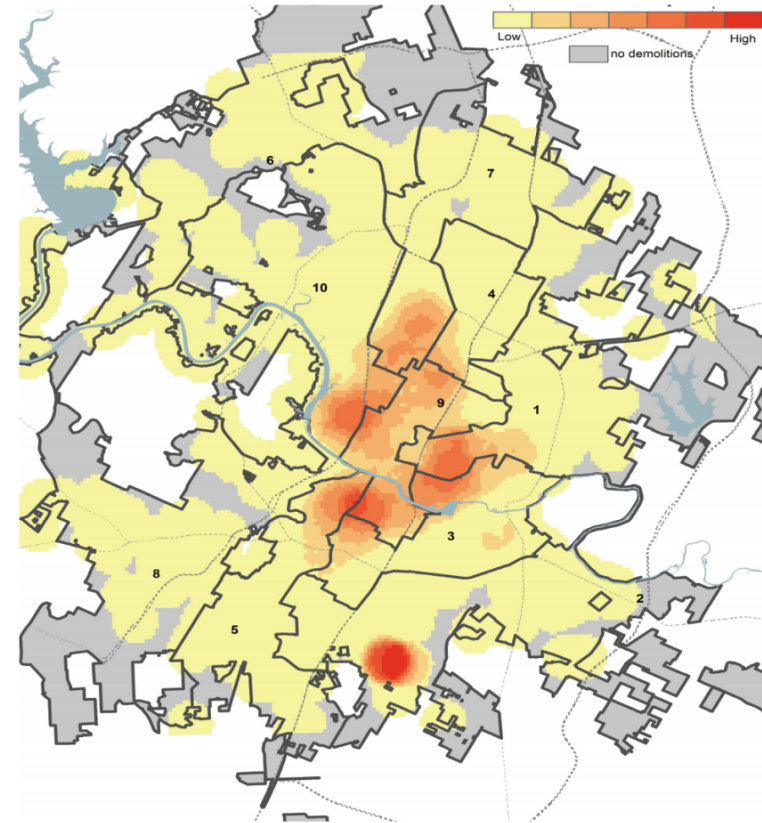


These are also some of the areas most vulnerable to economic displacement (but still home to many low-income people and diverse communities), as well as intensifying climate events.

Climate Resilience & Flooding

- **GAVA is focused in neighborhoods where rates of chronic disease and childhood obesity are highest. In Southeast Austin, they are also downstream.**
- **Because of structural inequities across race and class, and decades of underinvestment in the built environment, these are also some of the areas most vulnerable to economic displacement (but still home to many low-income people and diverse communities with rich social cohesion), as well as intensifying climate events.**

Appendix A - Density Map of Property Locations for Approved Demolition Permits, FY08 to FY16



Community Engagement in Neighborhoods and Schools



Campaigns for prevention and health care

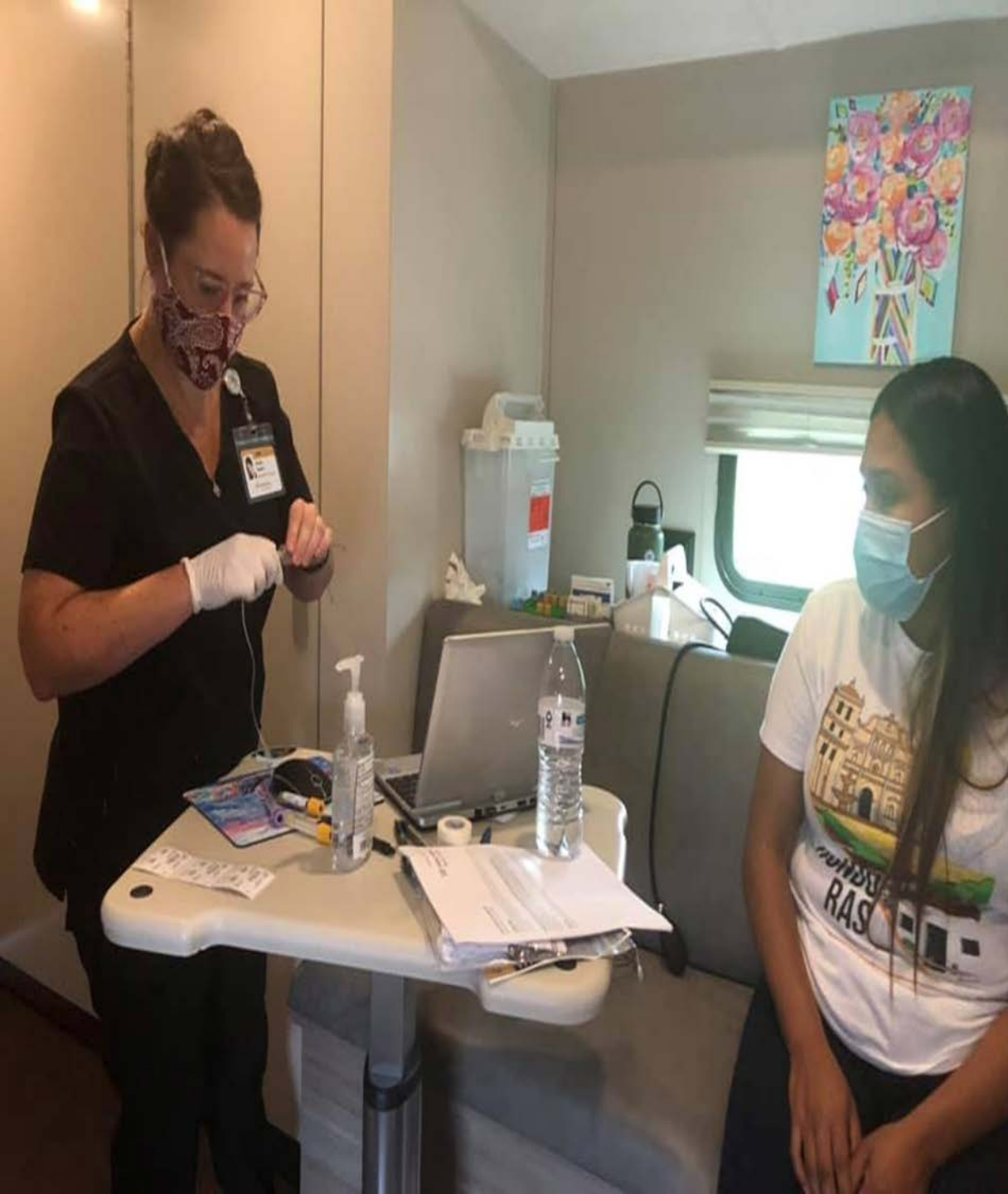
Health is a Right for All

Building Healthy Communities

Education for Better Living

Prevent Rather than Suffer







MOBILE
HEALTH
CLINIC

N NOVANT
HEALTH

Mobile mammography

FREE FLU SHOTS

FRIDAY, OCTOBER 23

1PM - 7 PM



- Free flu shots - Delicious hot soup
- Free clothing closet - Free masks

(336) 705-2475

5490 Shattalon Dr, Winston Salem, NC 27106



COVID's Emergency Response

- * Empathy**
- * Solidarity**
- * Vision**
- * Communication**
- * Taking Risks**



**SECOND
HARVEST
FOOD
BANK**
of northwest nc

**APRIL 27
- MAY 1**

loveoutloudws.com/food-map

WINSTON SALEM DINNER DISTRIBUTIONS

**HEALTHY
GRAB & GO
MEALS**



**Drive Up or Walk Up
Options Available**

One Meal Available for each Child 0 - 18

Parents/Guardians able to pick-up without
children present

No Paperwork or ID necessary

MONDAY - WEDNESDAY - FRIDAY

**2:00 -
3:00 PM**

**MORNING STAR
MISSIONARY
BAPTIST**

1400 Fitch
Street, 27107

**WINSTON LAKE
FAMILY YMCA**
901 Waterworks
Road, 27101

**3:30 -
4:30 PM**

**LIFE
CHANGING
TRANSFORMATION
CHURCH**

2001
E 25th
Street, 27105

**5:00 -
6:00 PM**

**SHILOH
BAPTIST
CHURCH**

916
E 12th
Street,
27101

**5:30 -
6:30 PM**

**IGLESIA
CRISTIANA
SIN
FRONTERAS**

5490
Shattalon
Drive,
27106

TUESDAY - THURSDAY

**2:00 -
3:00 PM**

**ELEVATION
CHURCH
(GATEWAY
YWCA)**

1300
S Main
Street
27127

**3:30 -
4:30 PM**

**GREAT
COMMISSION
COMMUNITY
CHURCH**

3733
Ogburn
Avenue,
27105

**4:00 -
5:00 PM**

**FULTON FAMILY
YMCA**
385 W Hanes Mill
Road, 27105

**FIRST BAPTIST
CHURCH -
HIGHLAND AVE**
700 N Highland
Ave., 27101

**5:00
6:00 PM**

**WINSTON SALEM
NAACP**
4130 Oak Ridge
Drive, 27105

ST. JOHN CME
350 NW Crawford
Place, 27105

**6:00 -
7:00 PM**

**THE
LOVE
CHURCH**

4198
Cherry
Street,
27105

**6:30 -
7:15 PM**

**NEIGHBORS
FOR
BETTER
NEIGHBOR-
HOODS**

1650
Ivy
Ave,
27105



**COMENZANDO
23 DE MARZO
DE 2020**

WINSTON SALEM DISTRIBUCIONES DE CENA

La Conferencia de Ministros de Winston-Salem y Vicinity & Love Out Loud se han asociado con Second Harvest Food Bank de NWNC y nueve iglesias y organizaciones locales para distribuir cenas a las comunidades locales a partir del lunes 23 de marzo.

**COMIDAS
SALUDABLES
PARA LLEVAR**



**Lleguen en vehiculo o
caminando ambas
opciones disponibles**

Una comida por cada niño(a) de 0 - 18 años

Los padres / tutores pueden recoger sin las
niños presentes

No se necesita documentación ni identificación

NUEVE LOCALIDADES

**lunes -
viernes**



**2:00 -
3:00 PM**

ELEVATION CHURCH (GATEWAY YWCA)
1300 S Main Street, 27127
WINSTON LAKE YMCA
901 Waterworks Road, 27101
MORNING STAR MISSIONARY BAPTIST
1400 Fitch Street, 27107

**3:30 -
4:30 PM**

UNITED METROPOLITAN BAPTIST CHURCH
450 Metropolitan Drive, 27106
GREAT COMMISSION COMMUNITY CHURCH
3733 Ogburn Avenue, 27105
LIFE CHANGING TRANSFORMATION CHURCH
2001 E 25th Street, 27105

**5:00 -
6:00 PM**

NAACP
4130 Oak Ridge Drive, 27105
ST. JOHN CME
350 NW Crawford Place, 27105
IGLESIA CRISTIANA SIN FRONTERAS
5490 Shattalon Drive, 27106

★ ★ ★
CONGRATULATIONS

**THE HISPANIC TASK FORCE
OF FORSYTH COUNTY, NC**

**WINNERS OF LATINO
DIAMANTE AWARD 2020**

This award is presented each year, to honor individuals or organizations that are making significant contributions to the Latino/Hispanic Communities of North Carolina and whose success helps to enhance the image of the Latino/Hispanic community.





RADIO ONDA DE AMOR
Community and service

FaithHealth

Fall 2020

pg 8 \ **ON-AIR FOR LATINO FAITHFUL**

pg 4 \ The Growing FaithHealth Movement

pg 10 \ A Unique Lifeline that Kept Workers Afloat During Pandemic

pg 16 \ The Mission Call of Home

RADIO ONDA DE AMOR



MI COMUNIDAD TE TRAE CONSEJOS SANOS DE NUTRICION PARA UNA MEJOR CALIDAD DE VIDA

Martes, 5 de Enero

8pm

WWW.RADIOONDADEAMOR.COM



Rocío Sedo

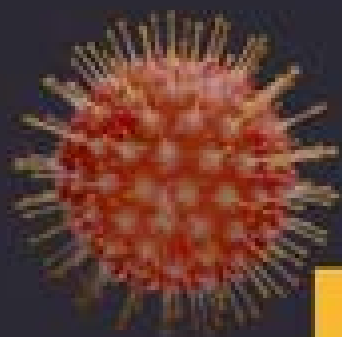
Rocío trabaja como educadora de nutrición para la cooperativa de extensión de NC University, realizando campañas y reuniones gratis para la comunidad hispana. Hoy nos habla de su programa "Comer bien y moverse más"

EN VIVO POR FACEBOOK LIVE Y EN NUESTRA APLICACION

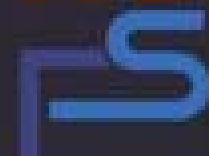
IGLESIA CRISTIANA SIN FRONTERAS/RADIO ONDA DE AMOR

**ASISTENCIA DE EMERGENCIA PARA
FAMILIAS HIPANAS/LATINAS
AFECTADAS POR EL COVID-19**

**USTED PUDIERA CALIFICAR PARA RECIBIR
AYUDA PARA SUS NECESIDADES BÁSICAS
Y SERVICIOS DE EMERGENCIAS**



THE
WINSTON-SALEM
FOUNDATION



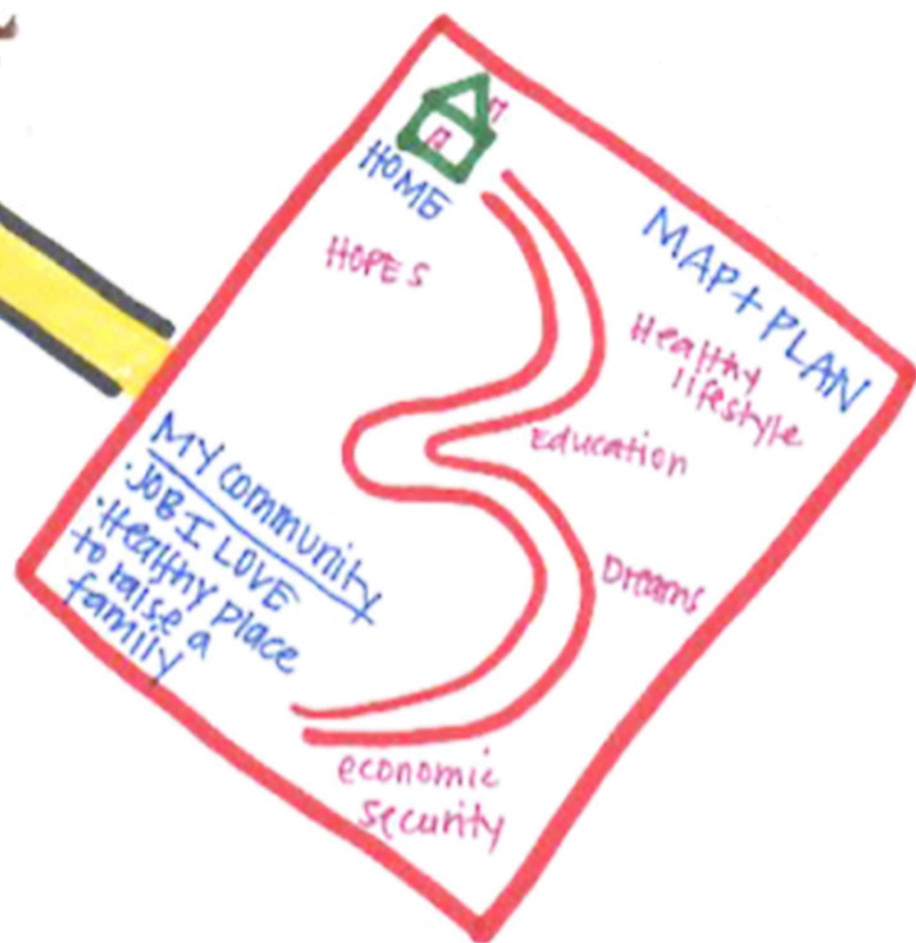
IGLESIA CRISTIANA
SIN FRONTERAS



RADIO ONDA DE AMOR
Community and Service

LLAMAR PARA MAS DETALLES AL: (336) 705-2475

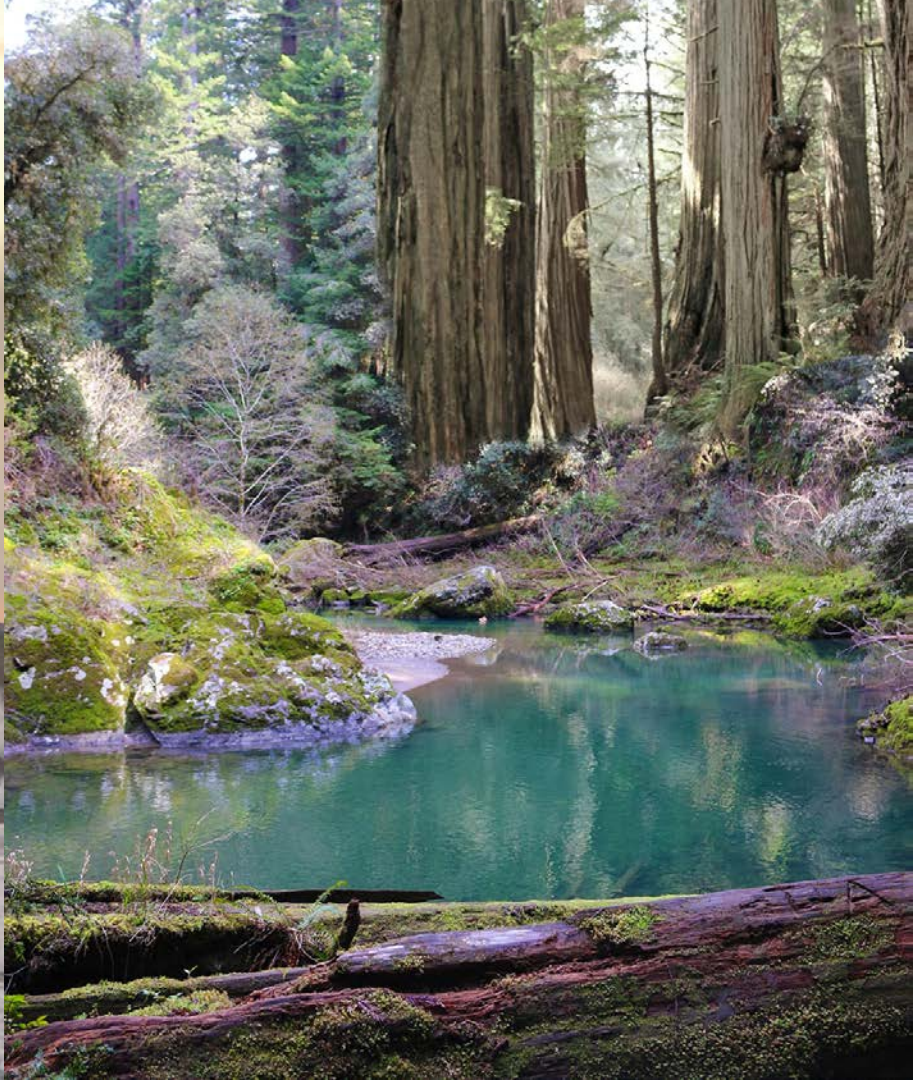




REAL EXPERIENCES →
REAL SKILLS & READINESS

- Experience turning a problem into a positive change in the community.
- Experiences interacting in the public arena to make real community change.
- Connection & real relationships with healthy adult mentors.
- Experiences making healthy choices.
- Experiences building leadership skills.
- Real work experiences











Sutter Health

Sutter Coast Hospital
Surgery Center











“I just try to
do what I can
to make my
community
a better place.”



Amplifying the Empirical-Base Linking Community Power & Health Equity

Hanh Cao Yu
Chief Learning Officer, TCE
Member of NAS Roundtable
Moderator of this Session

1) Aditi Vaidya – USC Equity Research Institute

HOW DO WE DEFINE **COMMUNITY POWER**?



- The ability of **communities** most impacted by structural inequities
- to develop, sustain, and grow an **organized base of people**
- who act together through **democratic structures**
- to **set agendas, shift public discourse, influence decision-makers, and cultivate ongoing relationships of mutual accountability**
- to **change systems** and advance health equity.

II. Ai-Jen Poo

*“Whether we are talking about the **future of health**, the **future of care**, or the **future of our democracy in this country**, we have to **put, at the forefront, the people our systems have failed the longest.***

*They hold the **solutions.***

If they get power, it benefits ALL of us and leads us toward the future we deserve.”

III. Tony Iton – From Technocratic to Democratic

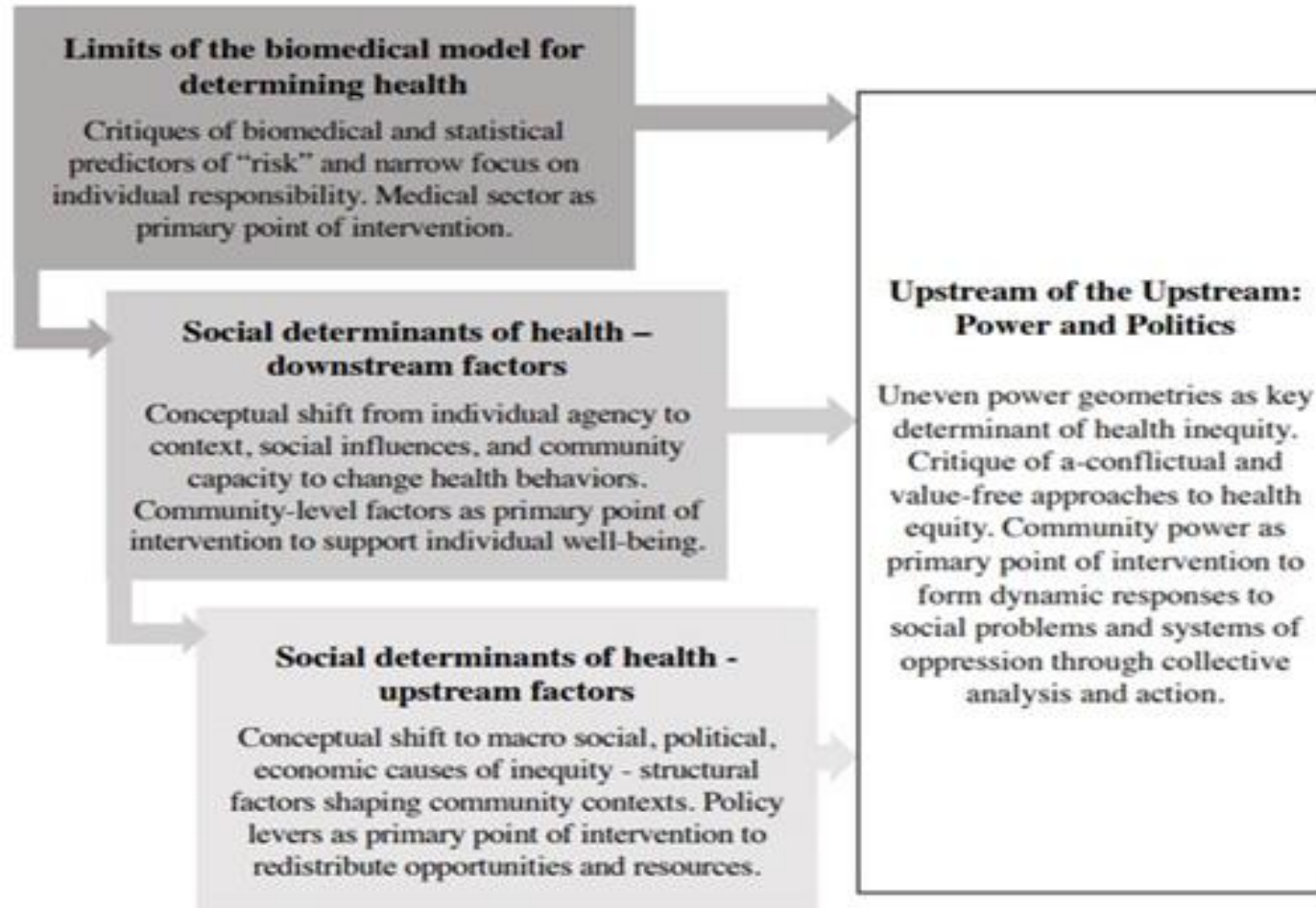


Figure 3. Conceptual Scaffolding Supporting Community Power for Health Equity

IV. HAHRIE HAN reminds us:

As researchers & evaluators, we have the responsibility of *WHO*, *WHAT & HOW* we shine the light and to what end.

How do we support community power groups?

- Goals:
 - **Sharpen practice**
 - **Make visible** the work they are doing to **enable learning**
 - **Push boundaries** of strategic thinking
- Lessons
 - Lesson #1: Focus on **shared learning**
 - Lesson #2: Put **power, race, and inequality** at the center,
 - to recognize the **uncertain, dynamic contexts** within which the communities act.

Goal of Session

How does the evidence help us to make better policy and funding decisions? It's not a question of “*IF* we should support community power,” BUT “*HOW* do we better support community power building, to achieve racial and health equity? And with humility!”

We know that research and theory that the link community power & health equity (1) is nascent and (2) largely **conceptual rather than empirical**.

In order build a sustainable, long-lasting power infrastructure, funders need to invest more and partner better.

YET, there are still many skeptics out there.

Goal of Session

- To explore the **empirical evidence-base** that **links community power with health equity** outcomes
- Draw implications for knowledge & practice
- To support Community Power Building.

Our Panel – *Why are you personally passionate about CP?*

Speakers	Topic of Presentation
Paul Speer , Ph.D., Professor, Vanderbilt University.	CHALLENGES & TENSIONS IN THE EXERCISE OF COMMUNITY POWER: PRACTICE IMPLICATIONS FOR RESEARCH
Tia Martinez , J.D., M.P.P., is CEO of ForwardChange	TCE Building Healthy Communities: Key Lessons Learned, including the role of funders
Bill J. Wright , Ph.D., Director, CORE @ Providence Health & Svc	BUILDING EVIDENCE FOR POWER & HEALTH THE BHC INITIATIVE AS A LEARNING ENGINE
Teresa Cutts , Ph.D. faculty at the Wake Forest School of Medicine Public Health Division	Community Power and Health Equity: Memphis Model's Cardiac Disparity Case Study
Laura Parajón , M.D., M.P.H., Professor, U. of NM, Deputy Secrt of Health for the Dept. of Health	Community Empowerment and Health Equity: Practicing community-based participatory research (CBPR) in the time of COVID

CHALLENGES AND TENSIONS IN THE EXERCISE OF COMMUNITY POWER: PRACTICE IMPLICATIONS FOR RESEARCH

PAUL W. SPEER

VANDERBILT UNIVERSITY

HOW DO WE UNDERSTAND COMMUNITY POWER?

SOURCE

WHAT IS THE BASIS
OR SOURCE OF THE
POWER THAT IS
EXERCISED?

NATURE

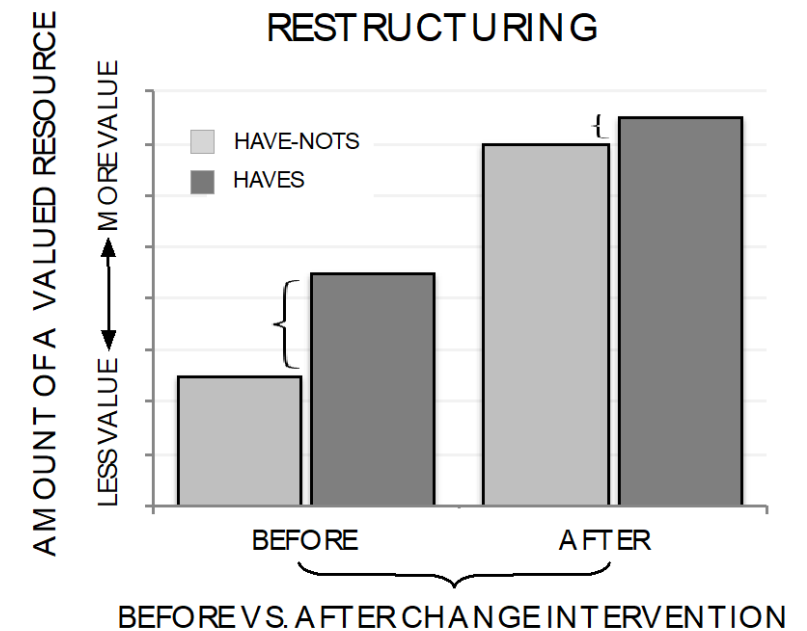
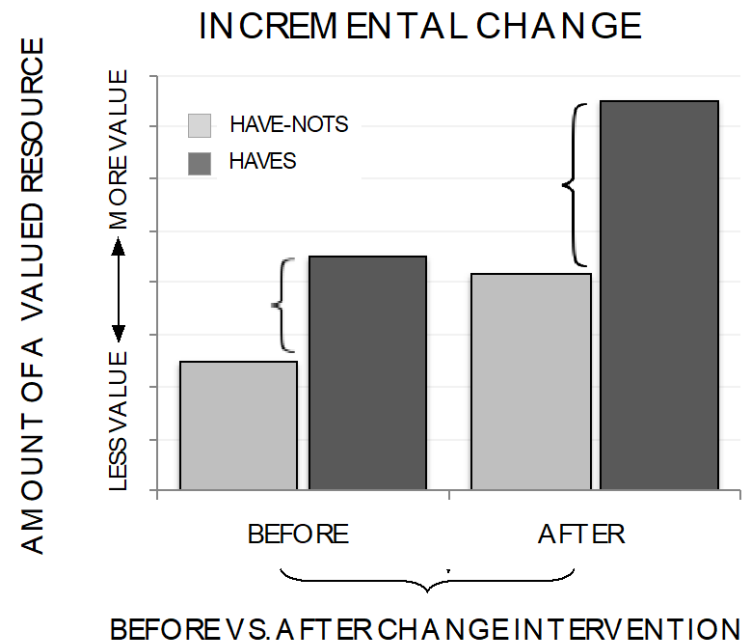
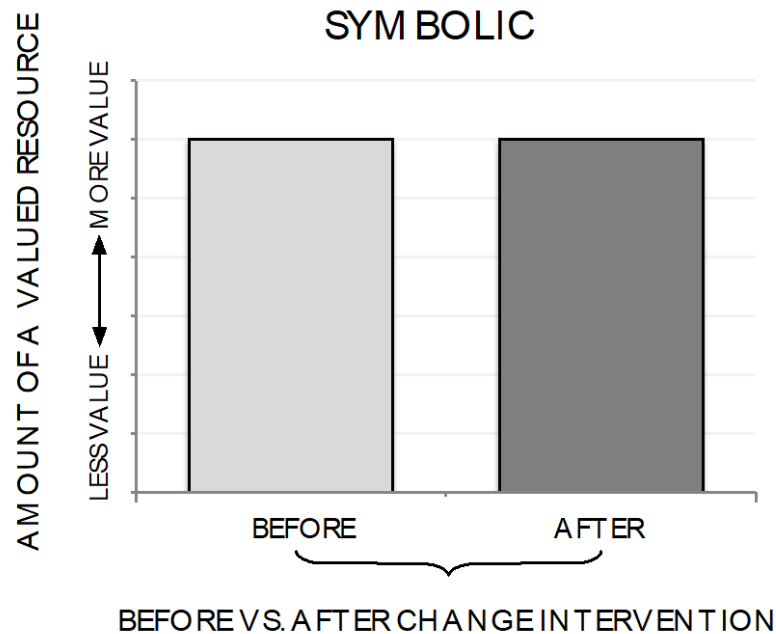
WHAT IS THE
UNDERSTANDING
OF HOW POWER
WORKS?

INSTRUMENTS

WHAT ARE THE
MECHANISMS
THROUGH WHICH
POWER IS EXPRESSED?

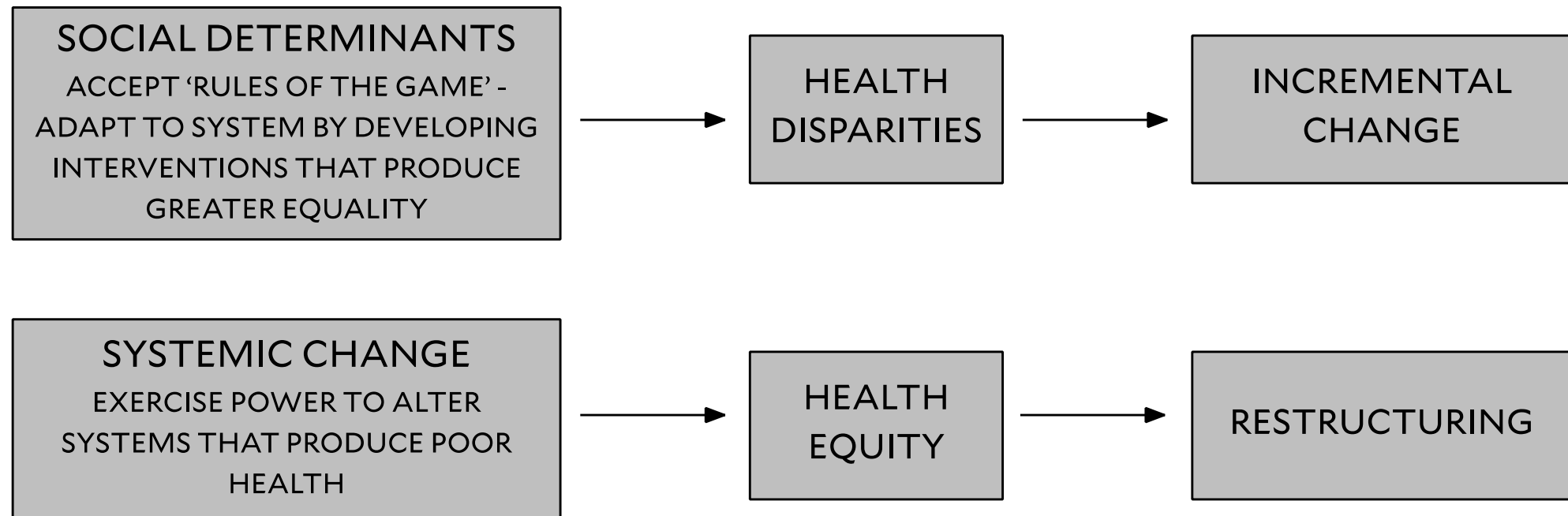
MINIMALLY, COMMUNITY POWER REQUIRES DEVELOPING A SOURCE OF POWER, AN UNDERSTANDING OF HOW POWER WORKS, AND STRATEGIES THROUGH WHICH TO EXERCISE IT.

HOW DO WE UNDERSTAND COMMUNITY CHANGE?



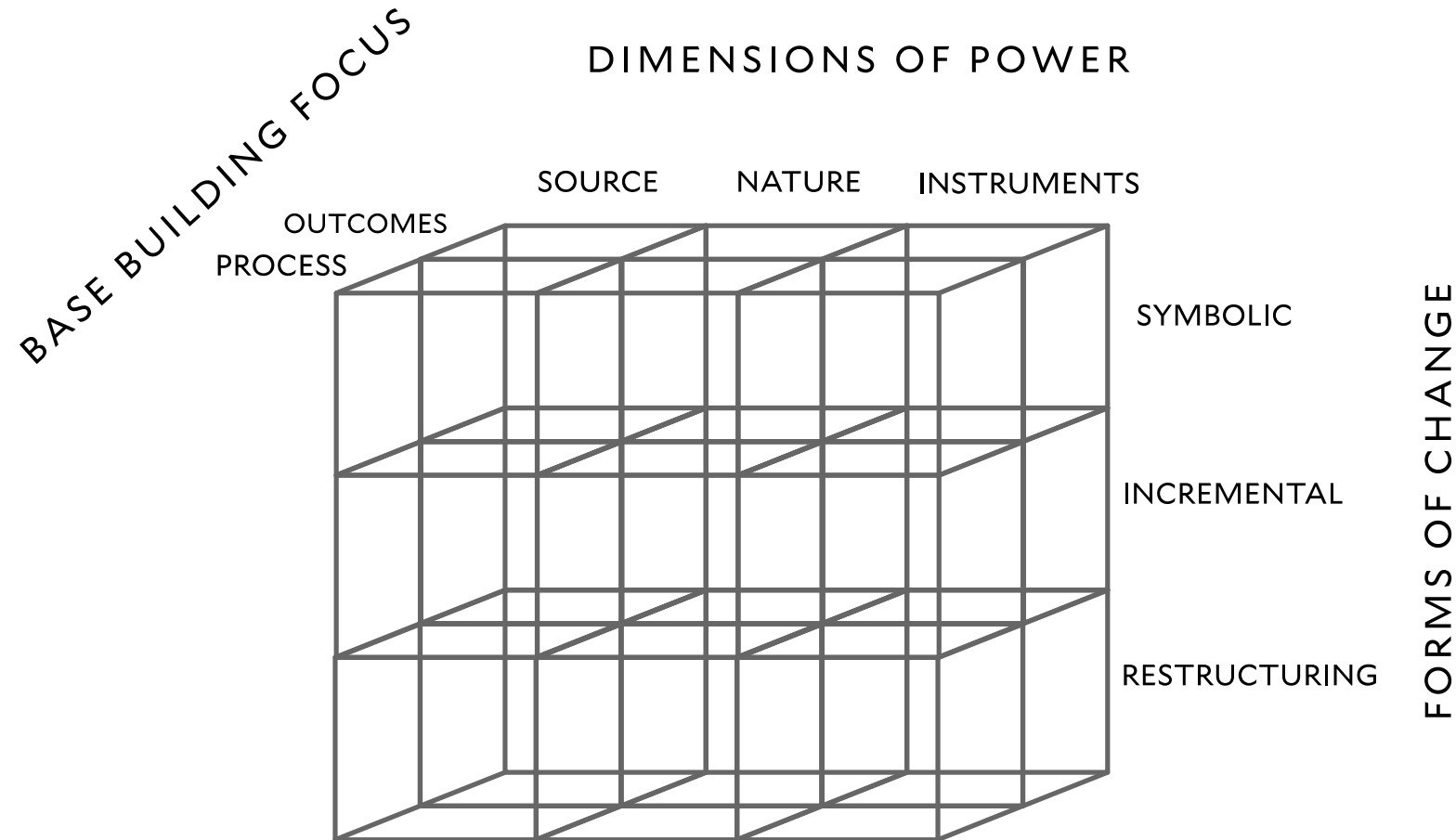
A FOCUS ON POWER IS NOT SUFFICIENT, WE MUST ALSO ATTEND TO CHANGE PRODUCED

HOW DO WE ADVANCE HEALTH EQUITY?



ADVANCING HEALTH EQUITY REQUIRES ALTERING THE DISTRIBUTION OF VALUED RESOURCES, AND ALTERING THIS DISTRIBUTION REQUIRES EXERCISING COMMUNITY POWER

HOW DO WE UNDERSTAND POWER & CHANGE?



ORGANIZING GROUP EFFORTS COMBINED WITH UNDERSTANDINGS OF POWER AND FORMS OF CHANGE ILLUMINATES THE COMPLEXITY AND NUANCE OF COMMUNITY INTERVENTIONS

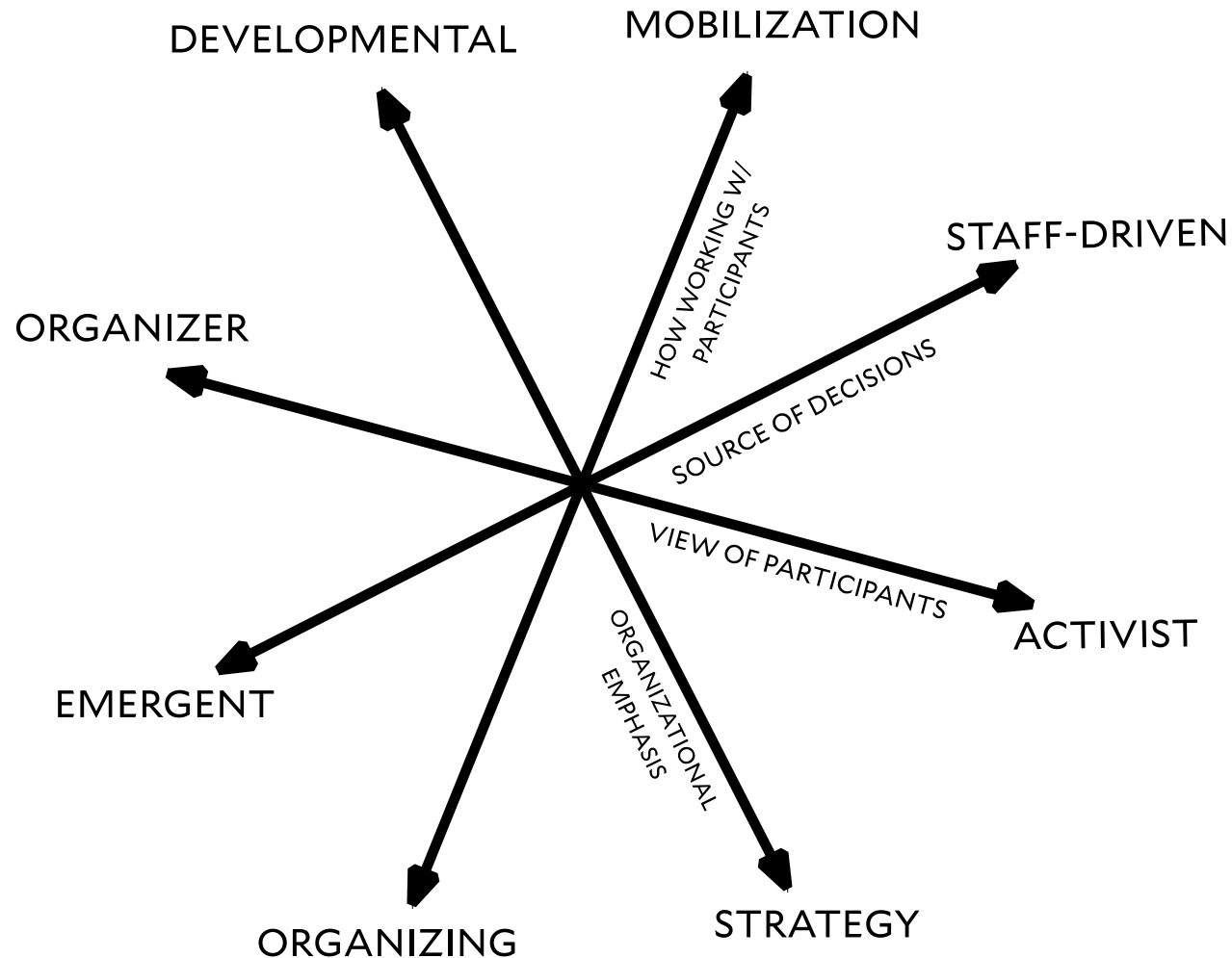
CRITICAL FOR RESEARCHERS TO SHAPE STUDIES CAPTURING DIVERSE PRACTICES FOR DEVELOPING COMMUNITY POWER TO LEARN WHAT IS EFFECTIVE

DIMENSIONS	DESCRIPTIONS / COMMON ALTERNATIVES
SOURCE OF PROBLEMS	PROBLEMS ARISE FROM DEFICITS OF PEOPLE OR LACK OF SKILLS AND/OR MOTIVATION
	PROBLEMS ARISE FROM CONDITIONS OF ENVIRONMENT
	PROBLEMS ARISE FROM SYSTEMS OF EXPLOITATION AND THE POWERLESSNESS THEY PRODUCE
CHANGE STRATEGIES	PEOPLE SOLVE THEIR OWN PROBLEMS RATHER THAN LOOKING TO INSTITUTIONS TO SOLVE THEIR PROBLEMS FOR THEM
	COMMUNITIES SEEK EXPERTS TO ADDRESS PROBLEMS; NEED FOR TECHNOCRATIC SOLUTIONS
	PEOPLE FORM COLLECTIVE POWER AND DEMAND CHANGES
CHANGE TACTICS	CONSENSUS-BUILDING, BETTER COMMUNICATION, EDUCATE PEOPLE, SOCIAL MARKETING
	SEEK OTHERS - EXPERTS, ELECTED OFFICIALS, HIERARCHICAL FIGURES - AND THROUGH RESPECT, KINDNESS, AND APPRECIATION RELINQUISH COMMUNITY RESPONSIBILITIES TO ELITES
	CONFRONT THOSE WITH POWER ABOUT HYPOCRISY ON VALUES, STATED CLAIMS, DEMOCRATIC PRINCIPLES; CONFLICT AND DIRECTION ACTION WHEN NECESSARY; NEGOTIATE WITH POWER TO ACHIEVE OUTCOMES
ORIENTATION TO POWER STRUCTURE	COLLABORATORS AND PARTNERS IN COMMON GOALS
	EMPLOYERS, SPONSORS, MERITORIOUS ELITES
	ACTORS EXTERNAL TO COMMUNITY WITH DIVERGENT INTERESTS FROM RESIDENTS

DIMENSIONS	DESCRIPTIONS / COMMON ALTERNATIVES
BOUNDARY DEFINITIONS	TARGET GEOGRAPHIC AREA
	TARGET RELATIONAL COMMUNITIES
	TARGET IDENTITY-BASED ALIGNMENTS (GENDER, RACE, ABILITY, CLASS)
	TARGET EXISTING GROUP MEMBERSHIPS (SCHOOL, FAITH GROUP, WORKPLACE)
ROLE OF ORGANIZER	TEACHER, CATALYST, BOOSTER, PROBLEM-SOLVER, BROKER, PLANNER, ANALYST, EXPERT, PROGRAM IMPLEMENTER, ACTIVIST, ADVOCATE, AGITATOR, PARTISAN, NEGOTIATOR
LOCUS OF INTERVENTION	POINT OF PRODUCTION - SITE OF EXPLOITATION (STRIKES, PICKETS, SLOW-DOWNS)
	POINT OF CONSUMPTION - VISIBLE ENDPOINT OF EXPLOITATION (BOYCOTTS, DEMONSTRATIONS)
	POINT OF DESTRUCTION - WHERE THERE IS HARM (STRIP MINE, LAND FILL)
	POINT OF DECISION - SITE WHERE ELITES DETERMINE POLICIES (BOARD MEETING, SLUMLORD OFFICE)
	POINT OF ASSUMPTION - CHALLENGES UNREFLECTED UPON BELIEFS (OCCUPY - 1% HOLD MAJORITY OF WEALTH)
OUTCOMES VALUED	EXPRESSIVE ACTION - FOCUS ON COMMUNICATING VALUES, CULTURE, OR EMOTIONS
	INSTRUMENTAL ACTIONS - FOCUS ON TANGIBLE CHANGE AND ACHIEVING GOALS

ATTENDING TO CRITICAL DIFFERENCES IN TACTICS, LOCUS OF INTERVENTION, AND OTHER KEY DIMENSIONS OF COMMUNITY-BASED PRACTICE MUST BE CONCEPTUALIZED AND MEASURED.

RESEARCH CAPTURING TENSIONS AND DILEMMAS IN DEVELOPING POWER ATTEND TO DIALECTICS OF PRACTICE



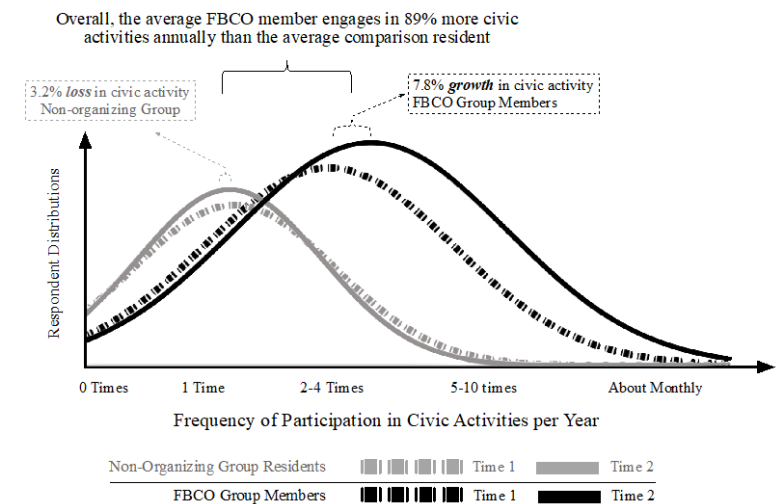
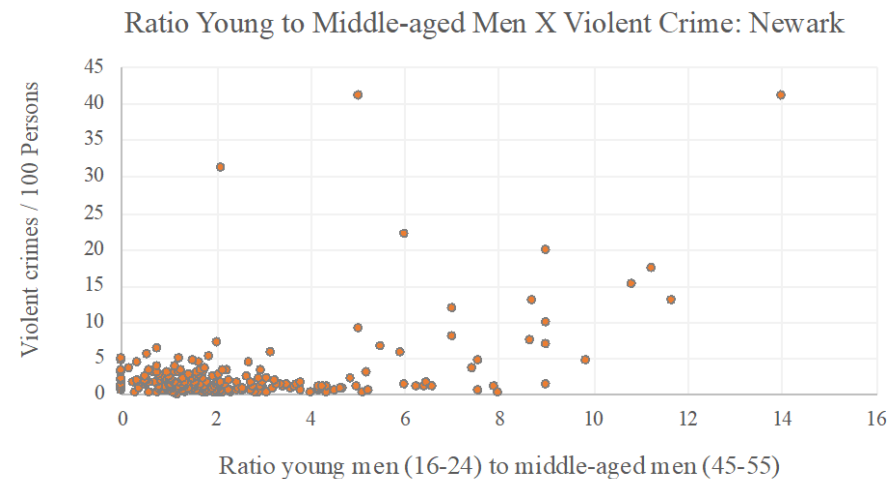
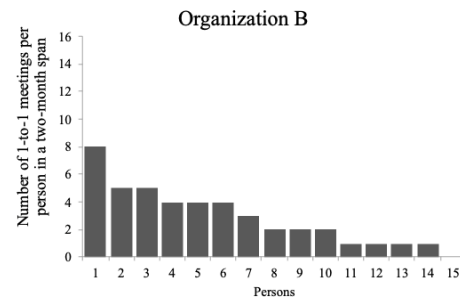
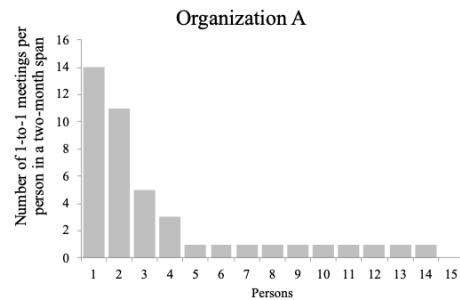
ATTENTIVENESS TO
THE COMMUNITY
DYNAMICS DRIVING
STRATEGIC DECISIONS
IN POWER BUILDING IS
KEY FOR RESEARCH

IMPLICATIONS FOR COMMUNITY POWER RESEARCH

MEASUREMENT OF
COMMUNITY POWER
BUILDING PROCESSES
SHOULD BE A PRIORITY
FOR RESEARCHERS

A GREATER FOCUS ON
RELATIONAL QUALITIES
OF BOTH POWER
BUILDING AND
COMMUNITY CHANGE

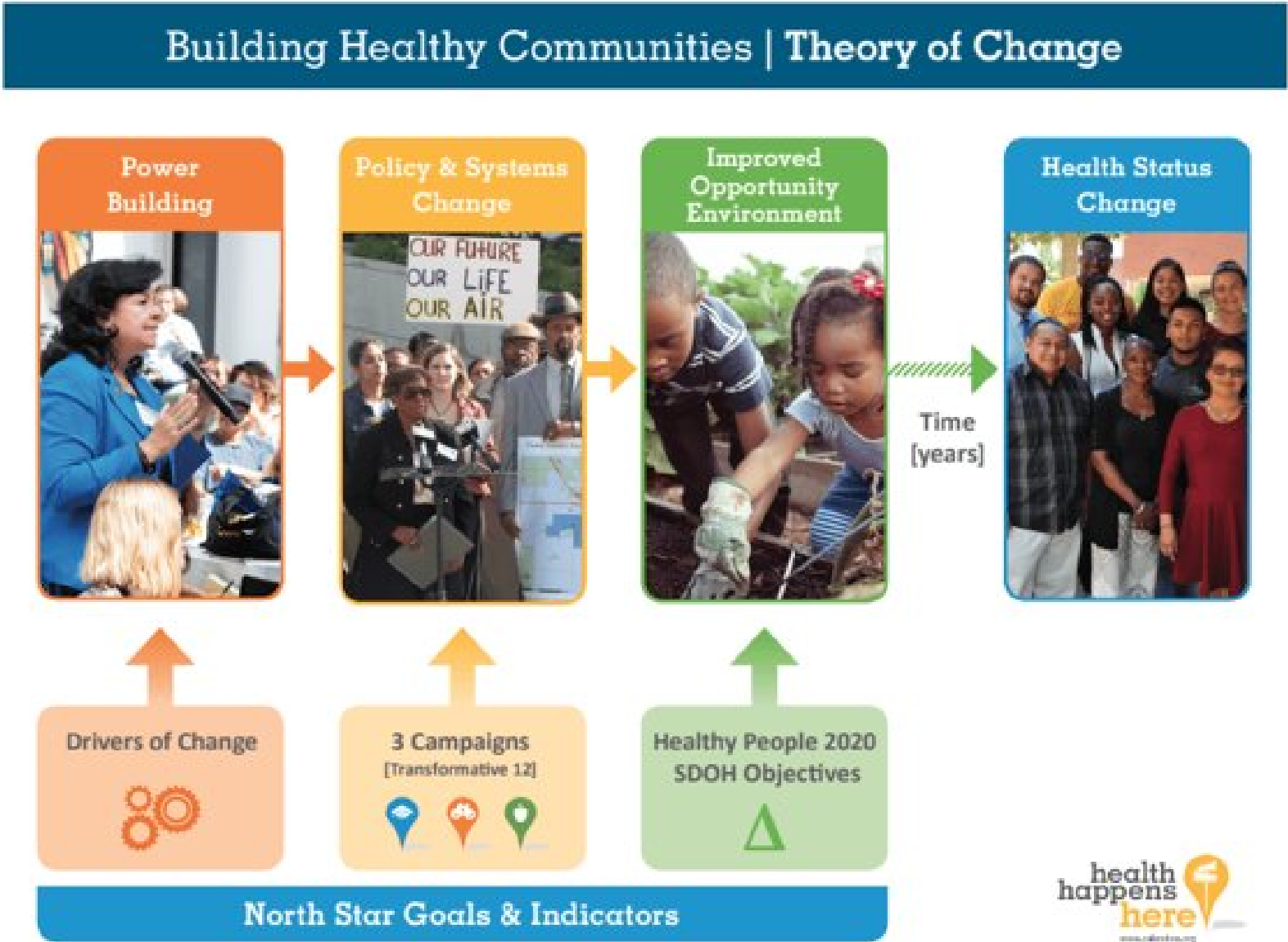
RESEARCH METHODS
THAT EXAMINE
LONGITUDINAL &
MULTILEVEL
RELATIONSHIPS IS KEY



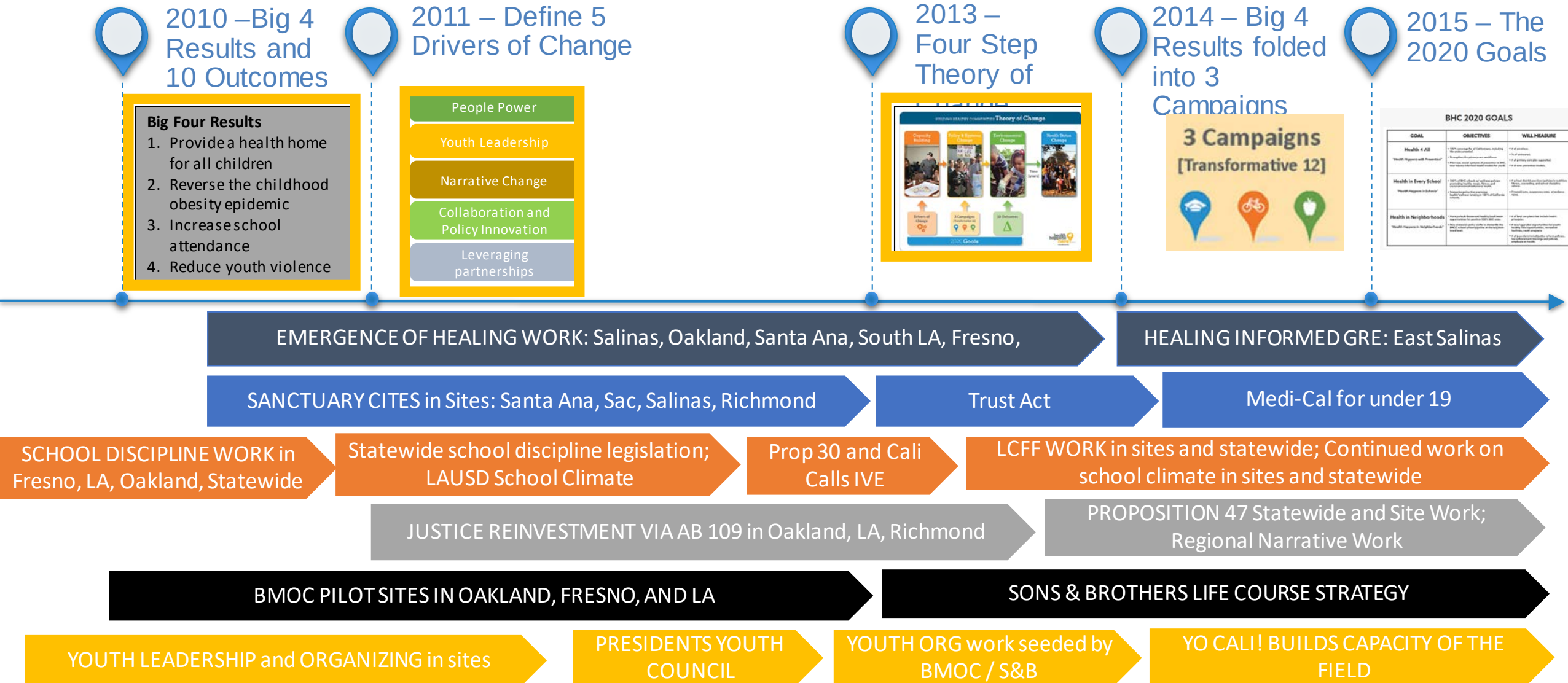
TCE Building Healthy Communities: Key Lessons Learned

January 2021

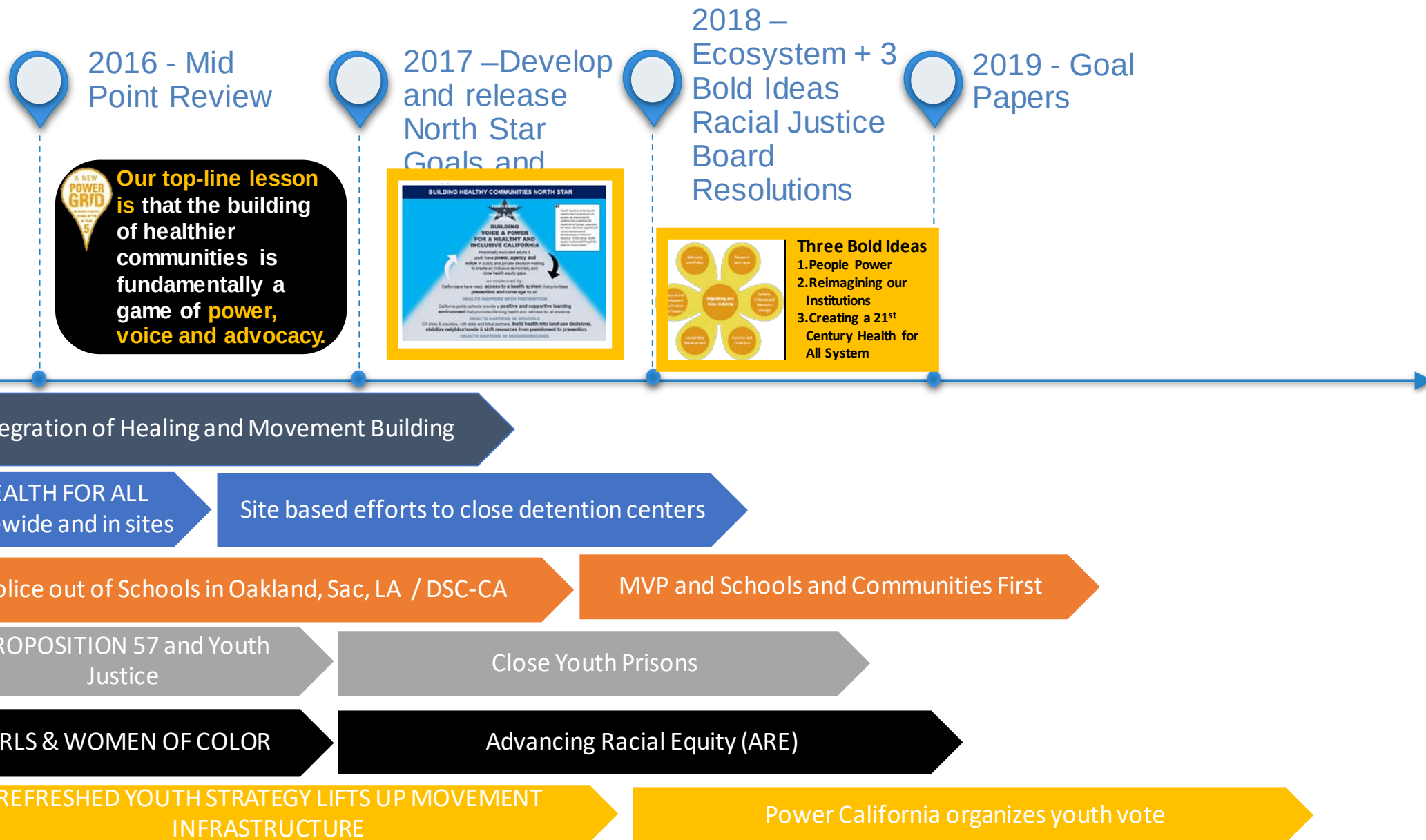
Background on TCE's Building Healthy Communities



For 10 years, we've been writing a story together...



For 10 years, we've been writing a story together...



Where We Landed: Centering Grassroots Power Building

North Star Goal #1



**Elevation of Power Building
from a secondary, instrumental
driver to a primary driver and
an end in itself.**

While we need multiple approaches and methods, grassroots power building for racial justice must be primary.

Flipping the script

from prioritizing grass-tops & funder leadership to
prioritizing grassroots leadership:

“During the first half of BHC, an emphasis has been on achieving health equity through professional advocacy and communications efforts bolstered by community voice and mobilization.... The health equity equation should lead with community organizing, leadership development, and grassroots advocacy—and then bolster those efforts with professional advocacy and communications.” (PERE 2018)

Lesson 1: Evolving our definition of “People Power”



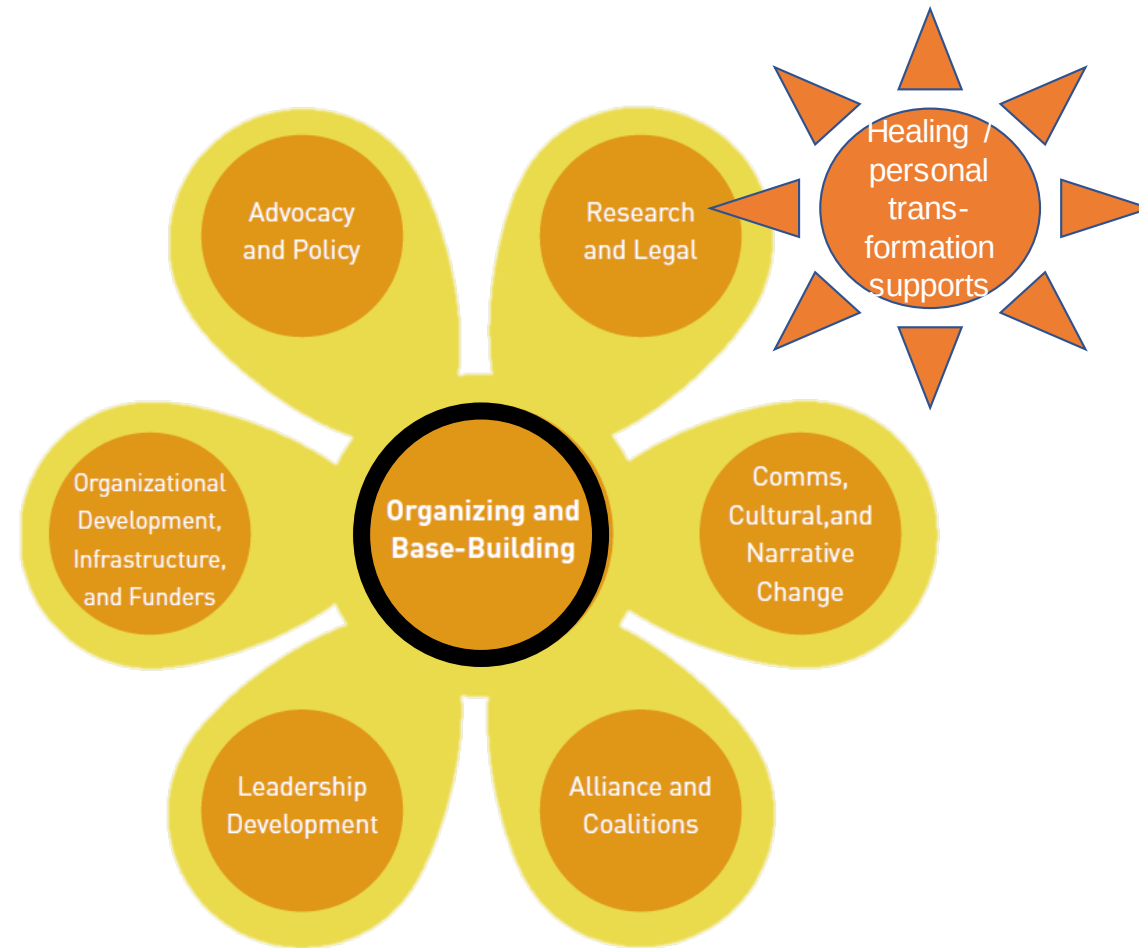
	BHC Begins: 2009-2010	Early Implementation: 2011-2015	Mid-Point Review: 2016-2018	Transition Planning: 2019 - In Progress
Definition of People Power	Resident Engagement <i>Large numbers of residents give input and bolster public debate and influence policy decisions</i>	Resident Agency <i>Residents collaborate to shape campaigns and programs that cause policymakers and system leaders to respond.</i>	Seeds of People Power <i>Community-led initiatives gain traction, find their stride and begin to flex their leadership to shape their own issues and approaches.</i>	Power-Building Ecosystem <i>Aligning diverse community-led initiatives toward greater mutuality and complementarity—with grassroots organizing at the center</i>
Role of Community	• “Residents give input” (bringing people to events)	• “Residents & their organizations possess agency” (begin developing new change proposals and programs).	• “Community organizations launch new initiatives and new vehicles” (new work in Healing Justice).	Each region and/or area of work evolves into a “powerbuilding ecosystem,” with grassroots organizing for racial justice at the center.
Foundation’s Role	• With results and outcomes pre-set by TCE, residents give feedback to shape the theory of change to generate these results and outcomes.	• Foundation-created tables bring together grassroots orgs, service orgs, and system leaders to collaboratively build solutions.	• The BHC becomes a node for resident-led formations to connect, build relationships, and get resources to grow.	

Lesson 2: Building power requires more than strong organizations—it requires an ecosystem

Organizing and base building groups are at the center – supported by allies and partners from diverse disciplines

A Power-Building Ecosystem

“Organizing and base building alone are insufficient to influence those who have the authority, resources, and power to make the kinds of decisions that will improve the lives of historically excluded people and reduce inequities. A broader ecosystem of organizations with diverse capacities, skills, and expertise—and with reach from the local to regional to the state levels—is required to get to the big goal of health and justice for all.”



Lesson 3: The crucial role of healing in movement work

While structural change through power building is always imperative, removing or reforming harmful structures will not automatically undo the psychological, spiritual, and physical damage done to our bodies, souls, and minds over generations. **It will not address how we are wounded internally by systems, history, and each other**

Without attention to healing, organizers, advocates, and community members can turn on one another or turn on themselves and self-destruct. **Rage can motivate us, but it can also destroy us and if turned on our colleagues and allies it can undermine a movement.**

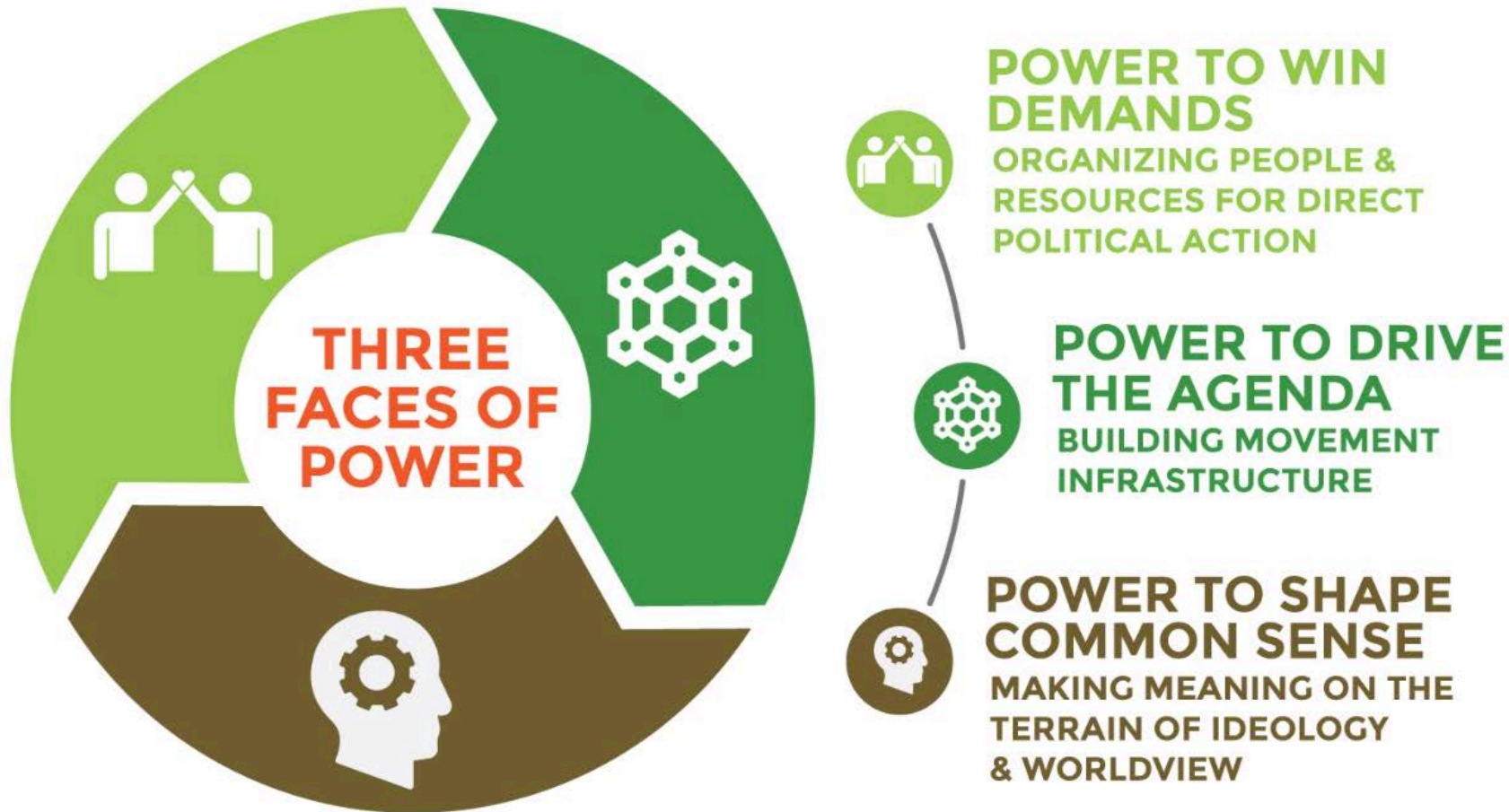
Healing-centered movement building enables the most impacted – and hence most hurt - by oppressive systems to fully participate as advocates and leaders in the movement by **proactively addressing their past and current internal wounds while at the same time building the critical consciousness needed for them to interpret the world and act to transform it.**

Lesson 4: Putting narrative strategy in service of grassroots power-building

	FROM	TOWARD
TCE's role in narrative strategy	▪ Inconsistent—in some places deep capacity building, at times bold and welcomed rapid response, other places perceived to undercut or conflict with messages from community partners. ▪ Lacking formal mechanisms for engaging community partners.	▪ Ensuring the work is led by community partners and grounded in power-building goals. ▪ Creating synergy between organizing and culture/narrative change work. ▪ Shared language and vision with our community partners.
Capacity building approach	▪ Transactional patchwork of communications firms/consultants (sometimes lacking cultural competencies). ▪ Lack of clear definition or criteria for what it means to provide effective supports.	▪ Developing an interconnected cadre of powerful grassroots organizations, cultural strategists and other narrative changers rooted in historically marginalized communities. ▪ Building a field around social justice communications--networks of people who connect and learn together over time.
Accountability	▪ No formal mechanisms to ensure that communications work is coordinated with/supportive of power building goals.	▪ Establishing narrative change as an essential component of a community organizing / power building approach.

Connecting the dots

Three faces of power



**Centering
“People Power”
as the engine**

**Building power
requires more than strong
organizations—it requires
an ecosystem**

**Putting narrative strategy
in service of grassroots
power-building**

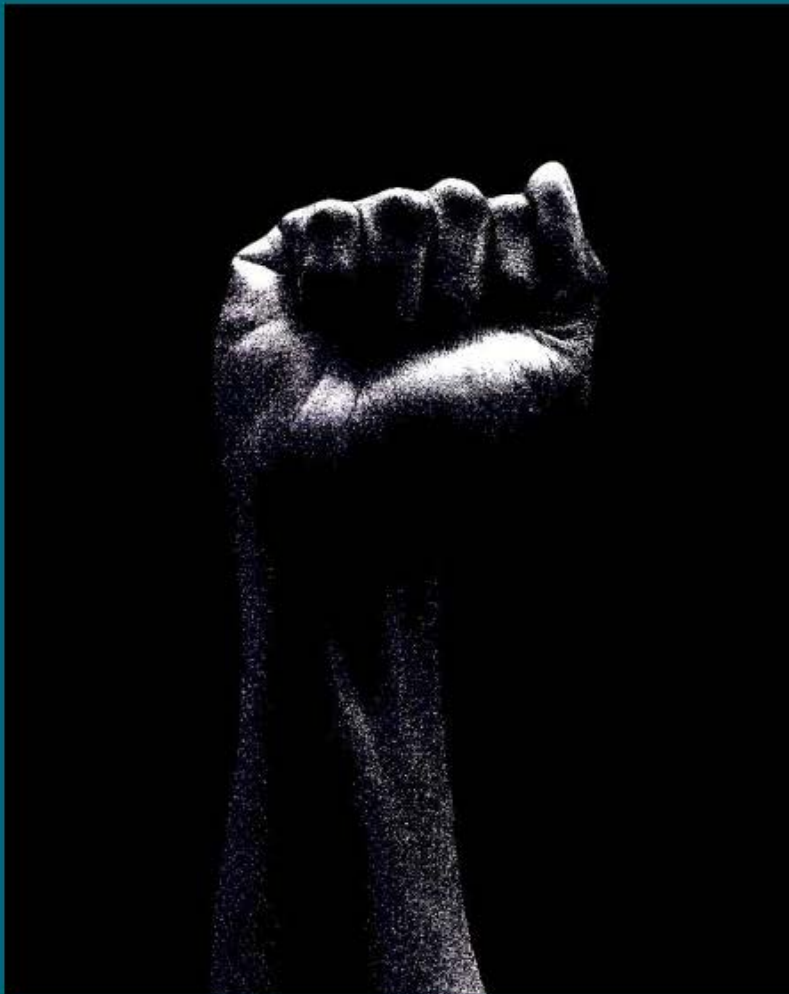
Source: Grassroots Policy Project

Lesson 5: Rethinking our role as funders

	FROM	TOWARD
Relationship to partners / grantees	▪ Telling / leading ▪ Power "over" ▪ Not transparent or consistent (from too hands on to too hands off)	▪ Let the movement lead ▪ Power "with" (in right relationship with) ▪ Feedback loop – listening & adjusting ▪ Being involved at the level and in the ways that grantees value
Measuring grantee success	▪ "Shiny" policy wins, rapid response ▪ Leveraging the insider-track ▪ Superficial "numbers" (e.g. "number of residents engaged")	▪ Systems transformation deeply rooted in the most impacted communities ▪ Generational change ▪ Developing new metrics for authentic power building
Program manager core competency	▪ Strengthening individual organizations	▪ Learning how to cultivate a robust movement ecosystem

BUILDING EVIDENCE FOR POWER & HEALTH

THE BHC INITIATIVE AS A LEARNING ENGINE

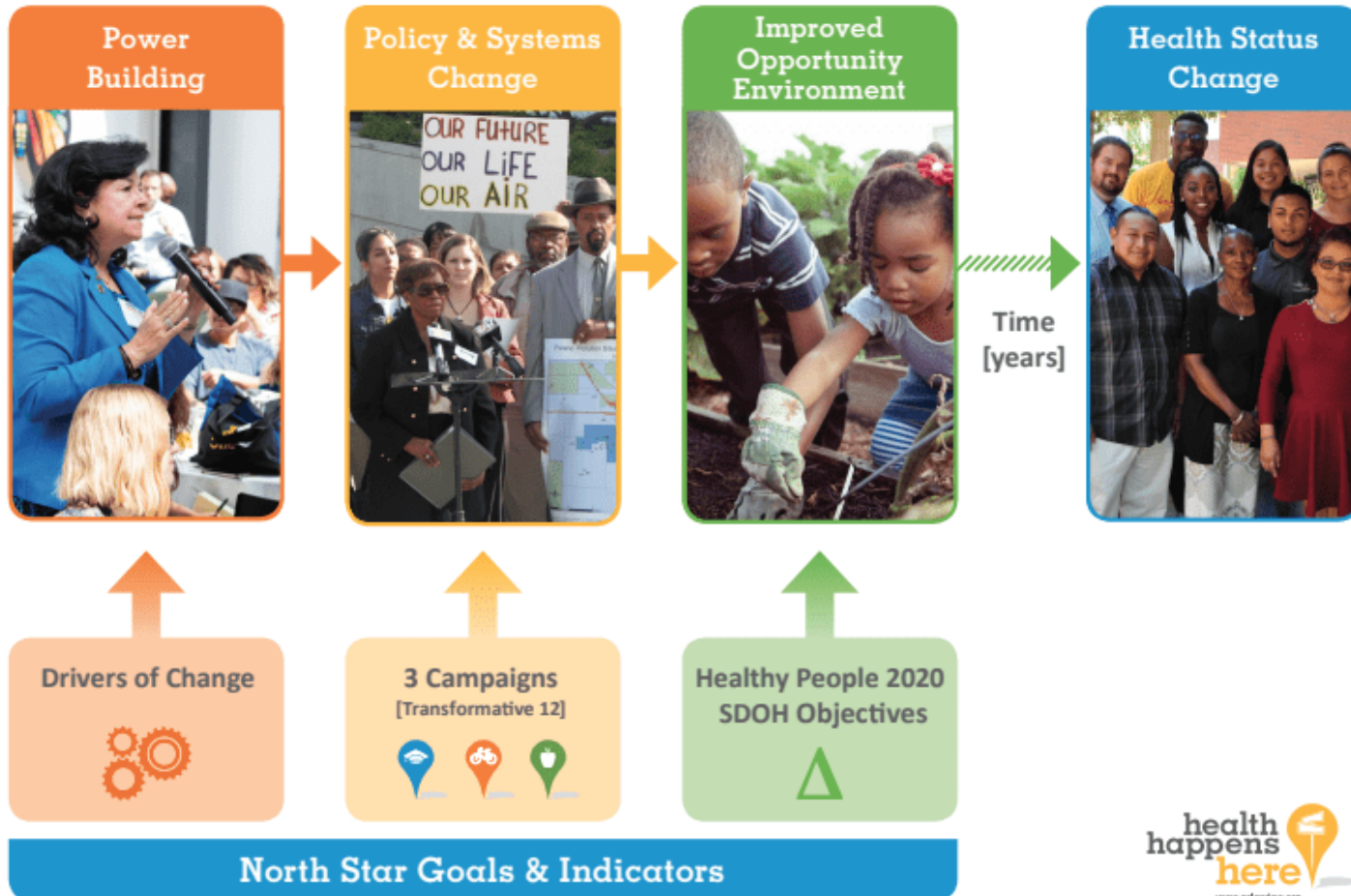


Bill J Wright, PhD
Executive Director
Center for Outcomes Research & Education
Providence Health System
Bill.Wright@Providence.org

CORE | Center for Outcomes
Research and Education

POWER AT THE CENTER -- THE BHC THEORY OF CHANGE

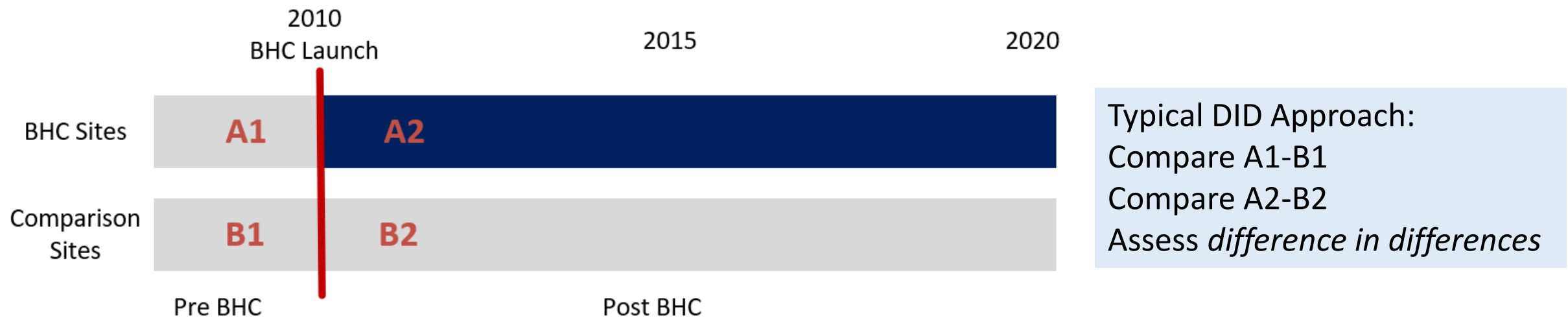
Building Healthy Communities | Theory of Change



- Both the **scope** and **nature** of BHC make it hard to “evaluate” in a traditional sense.
- Scope:** It’s over 10,000 grants, \$1.8 billion, in 14 places but also complementary statewide work.
- Nature:** BHC works on a theory of change that sees *power building* as the key strategy for addressing health equity.
- This means it’s not a single program, but a framework. Related activities & strategies are led by local partners, whose approaches are not prescribed.

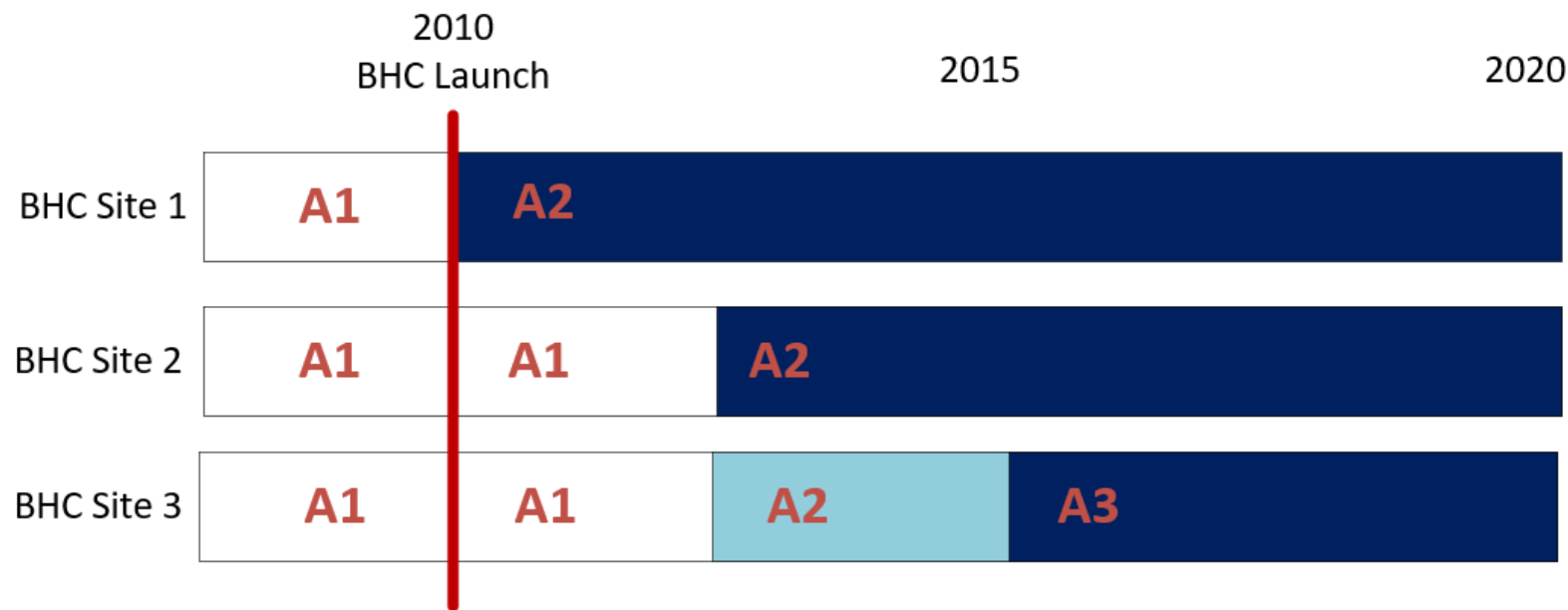
OUR USUAL SCIENTIFIC TOOLKIT ISN'T WELL SUITED TO THIS

Traditional evaluation tries **to measure impact** and **attribute it empirically** to a program or initiative's work. A typical approach might look something like this:



- Attribution of impact in evaluation is built on the fundamental idea of examining **variation across boundaries** – something happened in place x but not place y, or at time x but not time y.
- The “negative” side of these boundaries establishes a counterfactual we compare trends against. We use a range of empirical tools (DiD analysis, Interrupted Time Series designs, etc.) to make these comparisons.
- The problem? That’s all built around *programmatic* approaches to addressing health equity. When power building is the core strategy, all those boundaries are permeable *by design*.

PROGRAMMATIC VS. POWER BUILDING – A UNIQUE CHALLENGE



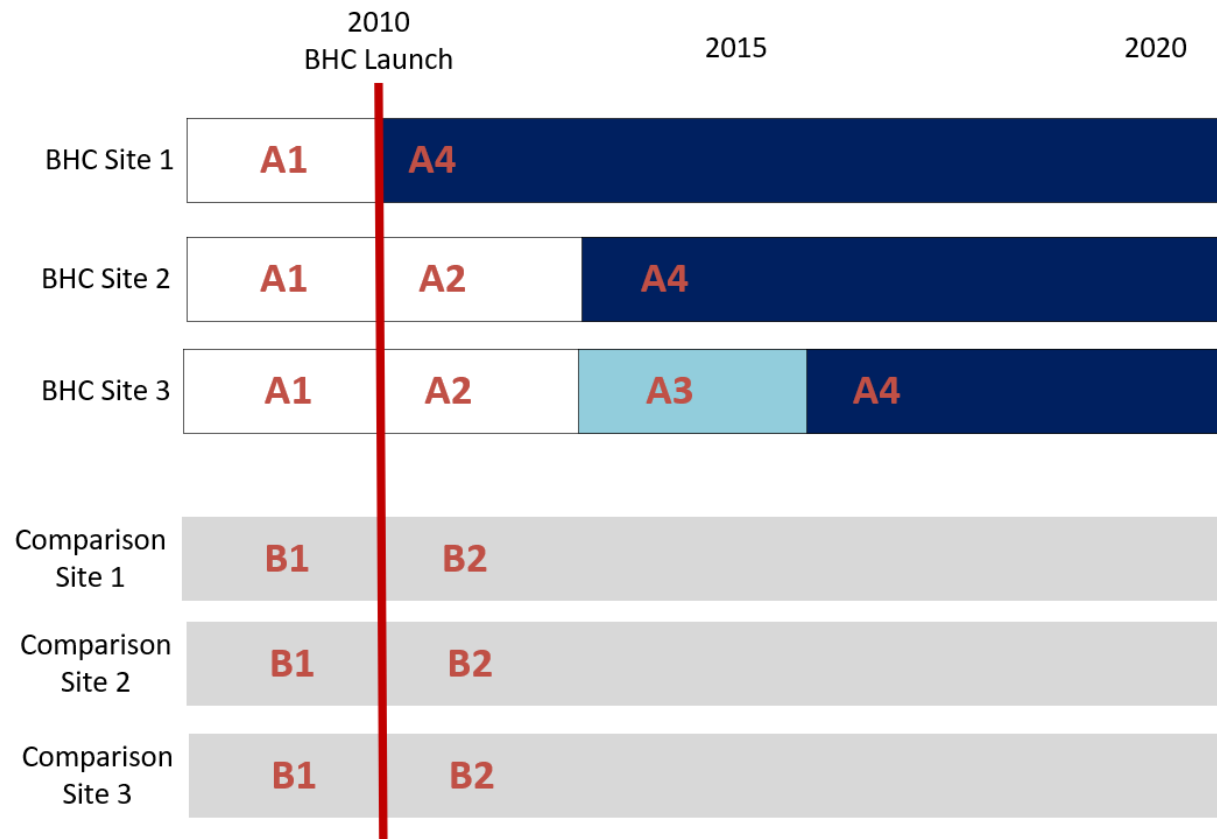
In programmatic approaches, we usually know the *who*, *what*, *where*, *when*, and *how much* of interventions.

When *power building* is the approach, all of that is up to the people on the ground doing the work – by design, we don't control it.

Relying on boundaries for attribution doesn't work when those boundaries are permeable by design:

- Boundaries of **place** are permeable – power, policy & systems changes, etc. aren't neatly contained.
- Boundaries of **time** are permeable – communities have been doing this work for a long time.
- Boundaries of **who & what** are permeable – the work is locally run & tailored to each community's context.
- In the end, a typical "block comparison" approach is likely biased toward the null.

BUILDING A “CONTEXT RICH” APPROACH TO MAXIMIZE LEARNING



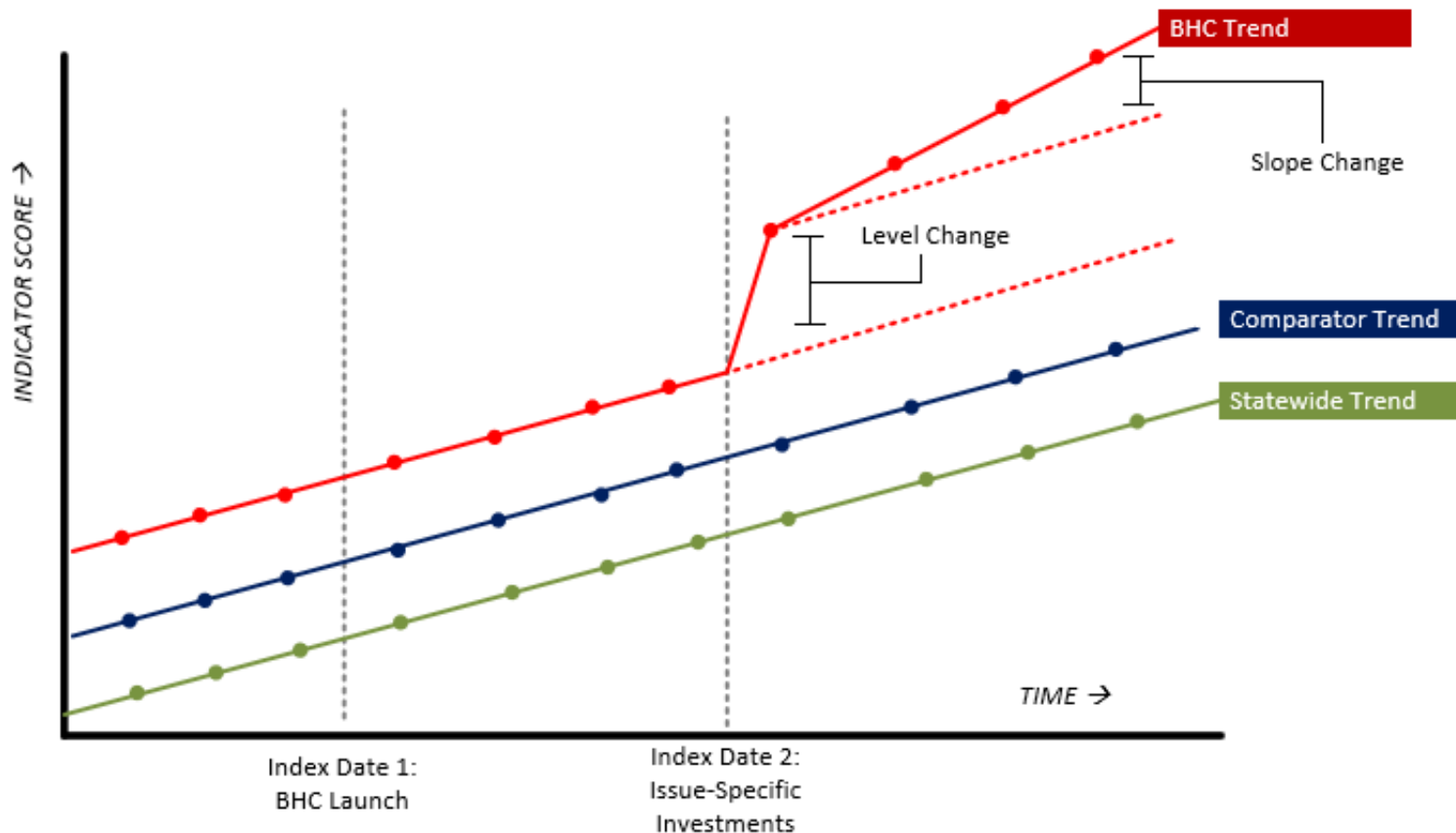
We need to consider a more nuanced, context rich approach:

- A1 should look like B1
- A2 should look like B2
- A3 should look better than B2, but not as good as A4
- A4 should look uniformly better than B2

- A “**context rich**” approach creates more boundaries for us to use for inference.
- We move beyond the simple boundary [BHC vs. not] to think more granularly about what happened, where it happened, and who it happened with. Those are boundaries as well.
- This approach makes local variation in the initiative a potential strength -- **a source of learning** rather than a hindrance.

TRANSLATING THE DATA RICH APPROACH TO AN EMPIRICAL TOOLSET

We can then translate the context rich approach to our more traditional tools. For instance, a CITS [comparative interrupted time series] design might look like this:



- For any given outcome, we identify what related activities happened and index when they happened.
- Time becomes a set of fixed intervals relative to those index dates.
- As we examine our outcomes over time, we compare trends between BHC and comparison communities relative to those index dates.
- Level change represents any immediate effects of issue-specific activities beginning in a BHC site. Slope change represents any sustained long-term impacts on the *trajectory* of a given outcome.

INTEGRATED MIXED METHODS TO CREATE THE DATA RICH APPROACH

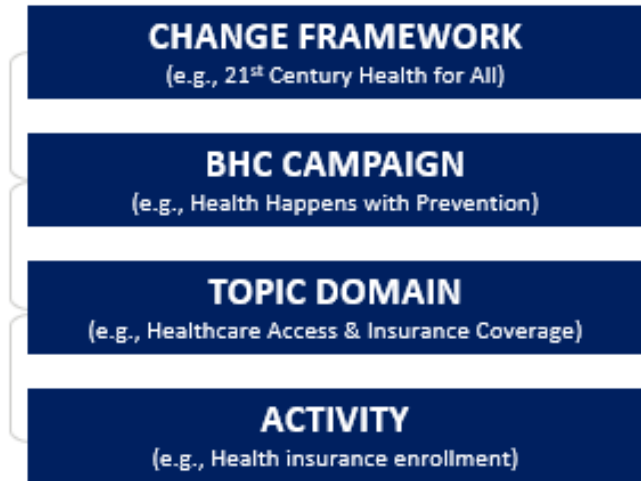
In a power building initiative, this essential context is only available to us if we take an integrated mixed methods approach.

BHC INVESTMENTS & ACTIVITIES	WHAT: Which activities related to a desired outcome were funded? WHERE: Where were those activities targeted? WHEN: When did the activities happen? WHO: What focus populations or groups were the activities targeting or supporting? HOW MUCH: What was the magnitude of the investment or support? ALIGNMENT: How well did BHC align with existing local priorities & efforts?
POWER BUILDING	PERSONAL: Indicators of engagement & participation in various community settings. ECOSYSTEM: Indicators of organizational capacity, networking, and power ecosystem.
POLICY & SYSTEMS CHANGE	LOCAL: What related local policy or systems changes occurred? When did they happen? REGIONAL & STATE: To what degree were wins connected to larger efforts?
OUTCOMES	OUTCOMES: Identified measures capturing desired long-term effects. DISPARITIES: Measures of gaps or disparities in identified measures.

DATA SOURCES: A mix of existing surveys, administrative datasets, & narrative data (grant descriptions and reports) that are coded & collapsed into discrete data elements for analysis.

- Narrative data [grant descriptions & reports] are coded & collapsed into discrete elements.
- Survey and administrative data are collected for all relevant geographies and subgroups across multiple existing data sources.
- All data elements are coded & tagged using a **universal coding framework** so they can be linked together in the context of the theory of change to build models.

USING MIXED METHODS TO CREATE THE ESSENTIAL CONTEXT DATA



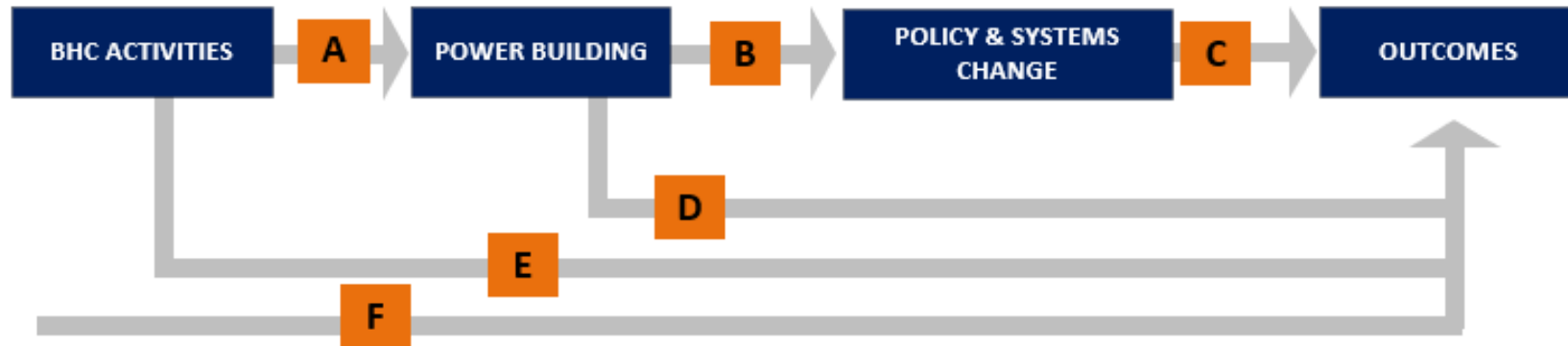
Grant & activity descriptions are coded and tagged to understand the *who, what, where, when, and how much* of each activity and which outcomes they might be expected to help generate.

Discrete data from surveys or administrative sources are coded and tagged to understand where they fit within the theory of change and which types of activities they might be related to.

Community and Economic Development (HHN) • Housing access & affordability • Resident displacement • Jobs, wages, & economic development • Social cohesion & community connections • Public transportation • Community centers	Healthcare Access & Insurance Coverage (HHP) • Health insurance enrollment • Continuity of coverage • Increased healthcare access
Healthy Youth Opportunities (HHN) • Youth community centers • Youth career development • Youth mentorship	Student Health & Wellness (HHS) • Physical health conditions • Mental/emotional health • Sexual health • Healthy eating & nutrition • Active students & physical activity • School built environment • School-based health centers
Restorative Justice (HHN) • Avoiding the prison-industrial complex • Pre-entry supports • Supporting incarcerated individuals • Re-entry & reconciliation supports • Safety & violence prevention • Trauma-informed practices	Neighborhood Wellness and Land Use (HHN) • Food environments and systems • Active transportation • Physical activity & recreation • Environmental health and justice • Health code enforcement • Land use & city planning • Health in city policies • Disaster preparedness & relief • Parks & green space
Immigration Reform (HHN) • Limit detention & deportation • Sanctuary cities • Pathways to citizenship	

- A **universal coding framework** is applied to all data to unify elements across the theory of change.
- All data elements are tagged for attributes like place, time, population, type of activity, and so on.
- For any given question, this allows us to select the most appropriate data elements across the theory of change, identifying relevant BHC investments & activities, measures of power building, policy or systems change, & outcomes indicators.

USING THIS APPROACH TO TEST THE THEORY OF CHANGE

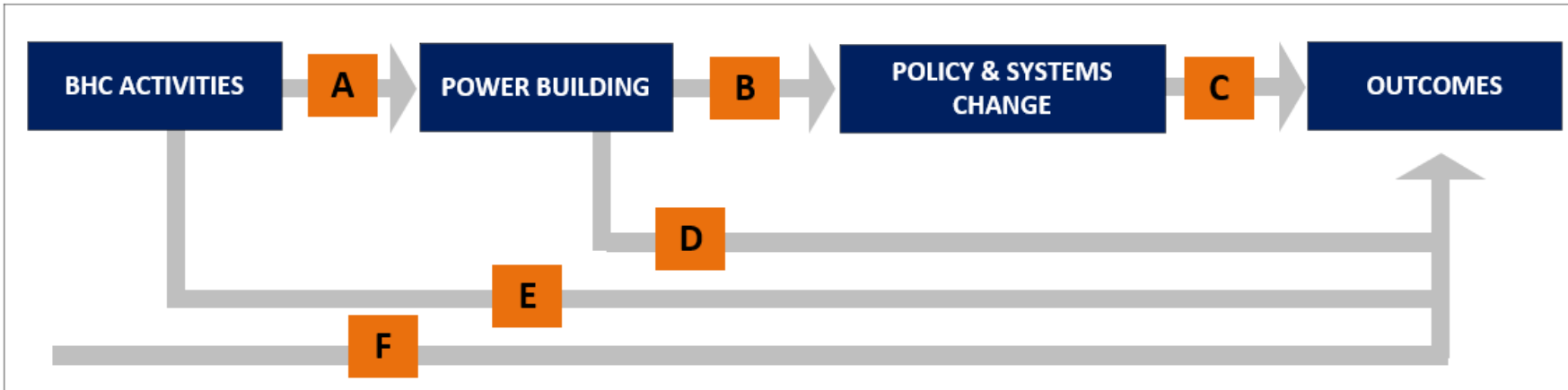


FOR ANY GIVEN OUTCOME....

- A** Variation in power building measures associated with BHC investments/activities.
- B** Variation in adoption of related systems changes associated with related investments.
- C** Variation in outcomes associated with adoption of related policy/systems changes.
- D** Variation in outcomes associated w power building but not via systems change.
- E** Variation in outcomes not associated with being a BHC site but not via power building.
- F** External trends in outcomes happening in the larger environment.

- We can overlay this framework on the BHC theory of change to understand direct & indirect effects of power building.
- We can “work back” from any given outcome to identify & test in context of the specific activities related to it.
- As we walk through the ToC, things that are outcomes in one stage [policy change] can be potential mediators in the next.
- Our ultimate goal is to assess how much variation is attributable to each pathway.

MOVING FROM PASS/FAIL EVALUATION TO A LEARNING SYSTEM



Results of Testing

Potential Conclusions & Lessons Learned

A+B+C upheld

The BHC TOC outlines the primary pathway for reproducing these outcomes.

A fails, B+C upheld

Power was built and mattered for improving outcomes, but BHC's investments may not be the main reason why. Consider new strategies to support power building.

C fails, A+B+D upheld

Power building helped improve outcomes, but the effect did not necessarily flow clearly through policy change. Examine alternate power effect pathways.

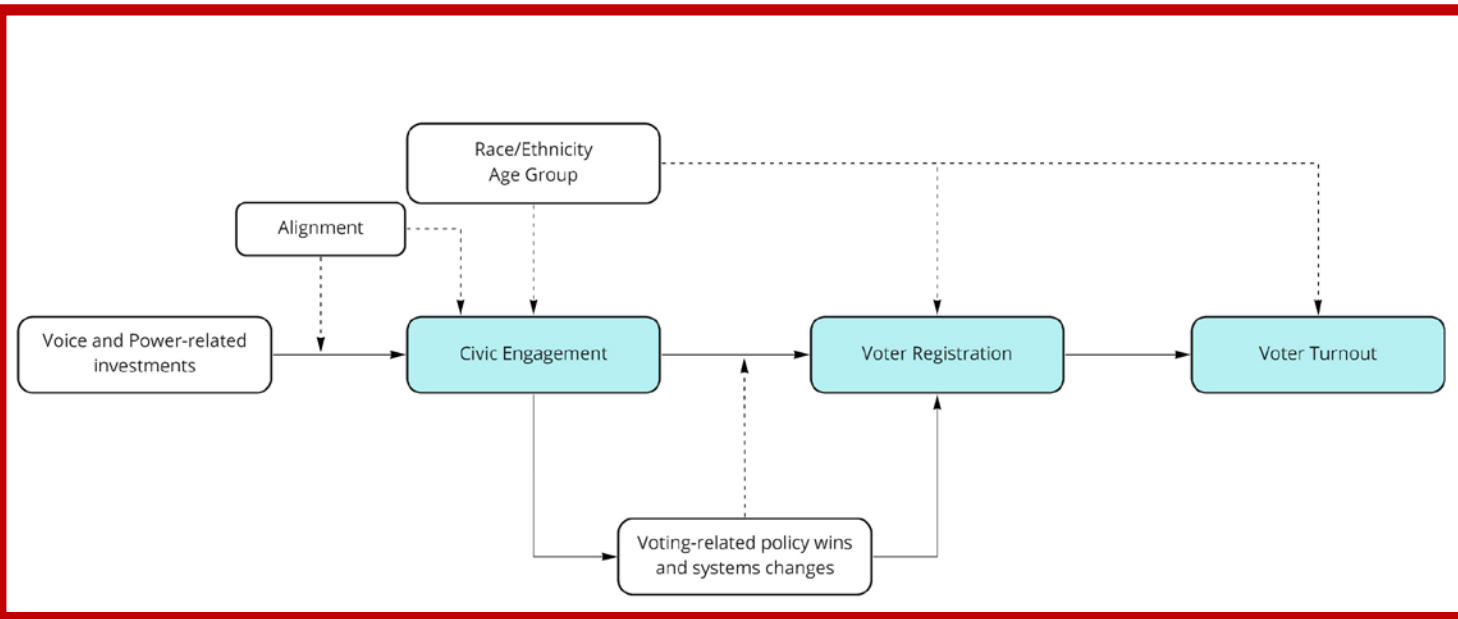
E upheld, A+B+C fail

Something about being in BHC helped move the needle, but not necessarily the BHC strategy. Look more closely at the role of the BHC resources & how they were used.

- This approach helps create a *learning architecture*.
- By testing different effect pathways across the theory of change, we can learn from the places where the data do or do not support rejection of a null hypothesis.
- We'll want to do this for a variety of pathways & contexts— there likely isn't a single uniform answer. There may be many different & nuanced stories to tell about the role of power building in addressing health & equity.

APPLYING THE FRAMEWORK: INVESTMENTS IN POWER & ORGANIZING

EXAMPLE: Were BHC investments in resident organizing associated with more active, civically engaged communities over time?



This is us exploring the first steps of the ToC logic model. It's an essential "stage one" of using the framework to trace any effects of power building work through to improved health outcomes at the community level.

OUR APPROACH:

We coded all 10,615 grants using our universal coding framework to capture the *who, what, where, when, and how much* of each.

We identified and tagged investments & activities related to resident organizing, voting rights, community voice, & representation in positions of power.

We identified potential indicators of an "engaged community" from various sources, such as voting records & community surveys.

We used the inference framework to build a series of multivariate models to test how responsive these indicators were to the power building work over time.

TESTING OUR FIRST INDICATOR: PARTICIPATION IN VOTING

	Voter Turnout B(SE)		Voter Turnout B(SE)
Investment per capita	0.001 (0.000)**	Investment per capita * Election	
Election		2012 primary (ref)	
2012 primary (ref)		2014 primary	-0.001 (0.000)
2014 primary	0.319 (0.022)***	2016 primary	-0.001 (0.000)*
2016 primary	0.432 (0.023)***	2018 primary	-0.001 (0.000)
2018 primary	0.193 (0.023)***	2012 general	0.000 (0.000)
2012 general	0.365 (0.008)***	2014 general	0.000 (0.000)
2014 general	0.178 (0.022)***	2016 general	-0.000 (0.000)
2016 general	0.075 (0.023)**	2018 general	-0.000 (0.000)
2018 general	0.517 (0.022)***	Unemployment Rate	0.003 (0.035)
		Home Ownership Rate	0.121 (0.018)***
		>90 th percentile Percent Minority	-0.206 (0.025)***
		>90 th percentile Percent Non-English	0.088 (0.032)**
		Intercept	0.115 (0.018)***

* p < 0.05, ** p < 0.01, *** p < 0.001

HEIRARCHICAL LINEAR REGRESSION MODEL:

Outcome: Voter Turnout.

Proportion of registered voters who voted in a given election, tracked by election type across 9 elections just prior to and during the BHC time period.

Independent Variable: Per capita investments in the selected domains in the two years before a given election.

Unit of analysis: Census tracts

Multi-level model with census tracts nested within sites & multiple observations nested within tracts

Other variables: Unemployment rate, home ownership rate, race/ethnic composition, % with limited English proficiency.

KEY FINDING: Overall, a \$5 change in investments (per capita) was associated with a 0.38 percentage point increase in voting participation. The effect varied by election type but was always directionally consistent.

LEARNING SYSTEM – USING THE DATA TO BUILD STRATEGY

KEY FINDINGS

Example: Long Beach



\$36

Average per capita investment in Long Beach, which corresponds to \$3.29M total investments in the selected domains over an average two-year period



+0.4%

The estimated average effect of a \$5 increase in per capita investments in power building on voting participation



\$431,000

The approximate total amount required to increase per capita investment by \$5 during the two years prior to an election

STRATEGY BUILDING

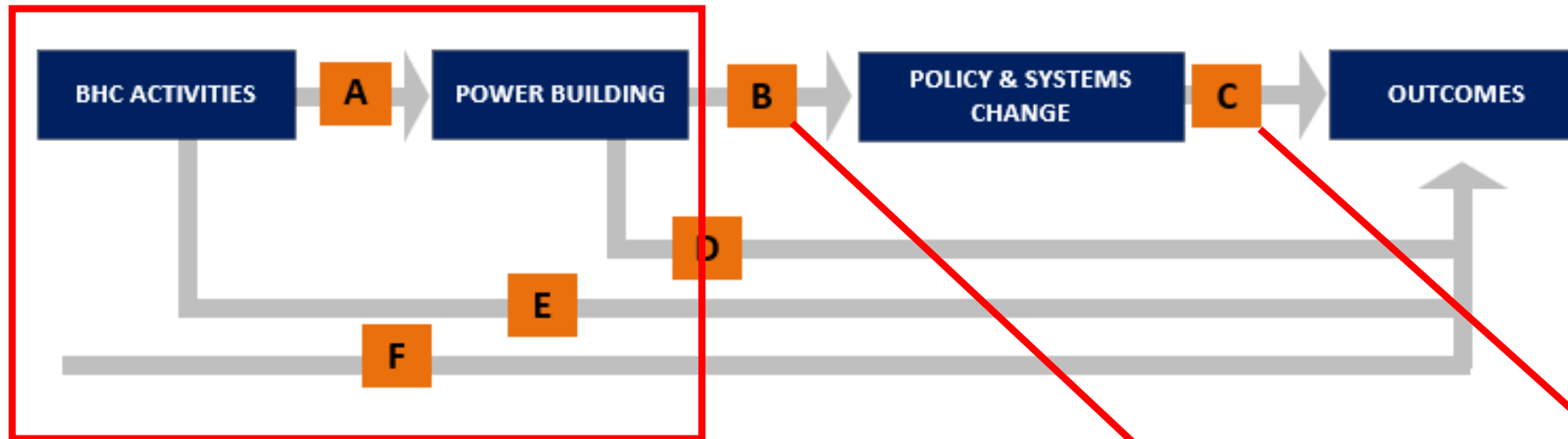
We can use these parameter estimates in a very practical way to help build strategy and inform the field about what it takes to move the needle.

We are working to create “impact profiles” that can help TCE & others understand what to expect in light of a given level of investment or activity.

When done across an ecosystem of connected outcomes, we can start to build a value case for the work.

WHAT'S NEXT: Voting is just one indicator of more engaged communities. Complete the picture by repeating this for other indicators of engaged and active communities. Then connect this to an assessment of health impacts in the same communities to test the BHC theory of change - and ultimately the relationship between power building & health.

LEARNING SYSTEM – USING THE DATA TO TEST THE THEORY OF CHANGE



DONE: We found that the kinds of resident engagement activities supported by BHC were associated with improvements in key indicators of community engagement & civic participation.

NEXT: Is there an association between improvements in those indicators & adoption of key policy changes?

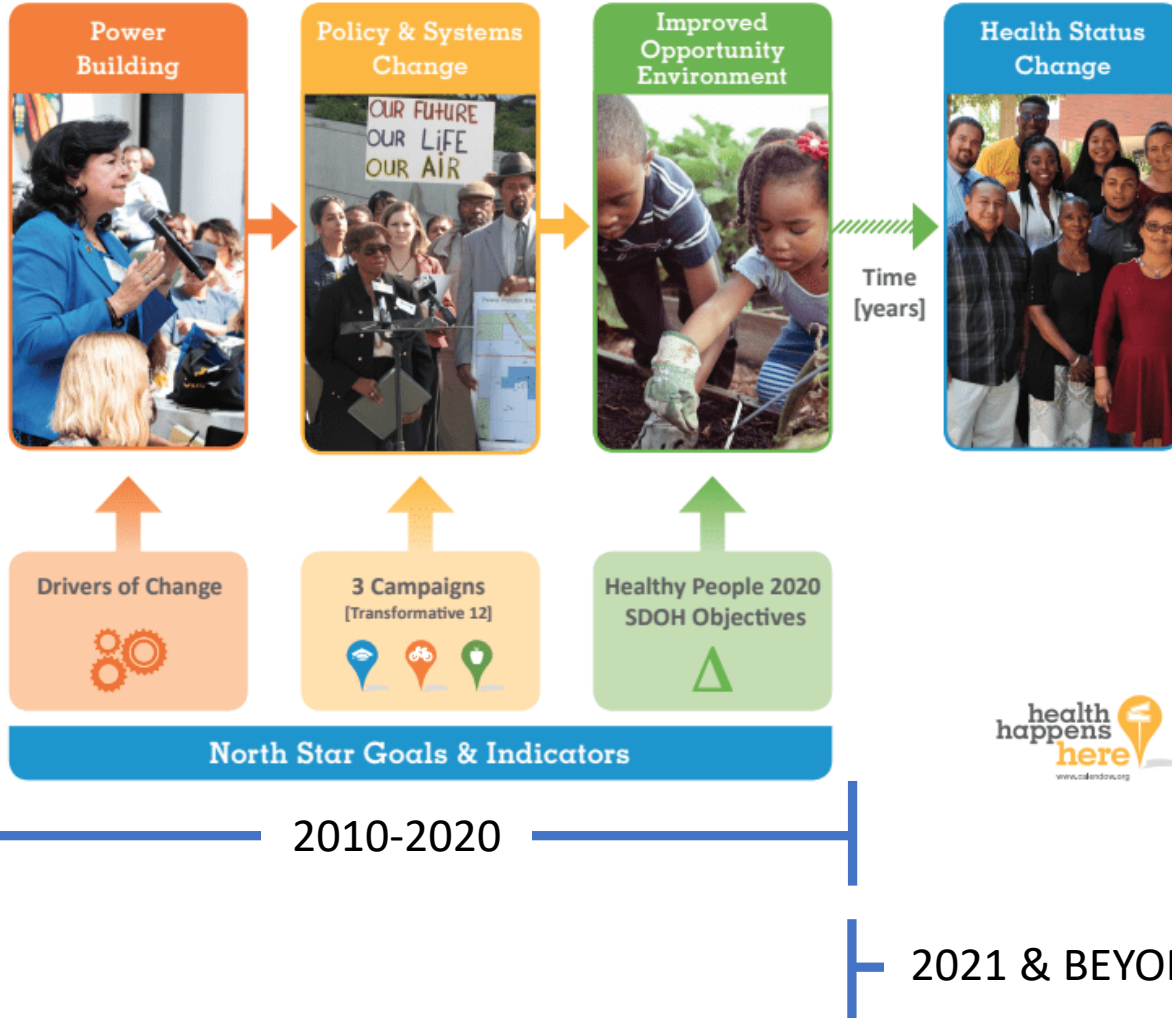
NEXT: Is there an association between improvements in those indicators & changes in key health indicators?

TESTING THE THEORY OF CHANGE

- Results like this also plug into our framework and help us test the theory of change, step by step.
- We can replicate this in a variety of contexts & outcomes. What does this look like in terms of BHC's goals & outcomes in its school campaign? Do we see the same patterns in youth-specific indicators & outcomes?

MOVING FORWARD: INVESTING IN GENERATIONAL CHANGE

Building Healthy Communities | Theory of Change



- The BHC Theory of Change represents a major shift in how you address health – from *programmatic responses* to *power building*.
- Because of this, it's critical we move beyond just seeing if BHC had an impact on some outcomes. We need to understand *how* that impact was created so it can be sustained & expanded.
- The more we take advantage of the rich variation within and across BHC communities, the more we can use BHC as a *learning engine* for the field at large.
- As we move forward, we can also embed this context-rich learning system approach into the day-to-day operations of TCE and its grantees, ensuring easier access to a rich and vibrant ecosystem of integrated data for future learning.

Community Power and Health Equity: Memphis Model's Cardiac Disparity Case Study

Dr. Teresa Cutts

Research Asst. Professor

Wake Forest School of Medicine

Division of Public Health Science

Maya Angelou Center for Health Equity

Jan. 29, 2021



Stakeholder Health

Health Through Community Partnership

Signaling Power

Lessons Learned about working in the space between community power and health equity

- Lens of the Congregational Health Network, specifically a cardiac case study which decreased sudden cardiac death rates in ~ 18 months
- Highlight practices “signaling” between community and collaborating health system to mitigate the asymmetrical power dynamics of partnership

Share thoughts on why establishing the evidentiary link between community power and health equity is difficult

Memphis: Egregious Health Disparities



Egregious disparity: Income, **Cardiovascular Disease**, Diabetes, Cancer, Suicide/Homicide, Infant Mortality

The Memphis Model or Congregational Health Network (CHN)

2006: Methodist Le Bonheur
Healthcare partners with
congregations & community
organizations to improve access
and health status for all.



Rev. Dr. Bobby Baker

**Director of Faith &
Community
Partnerships**



CHN Outcomes



- Charges for CHN vs. controls matched on age, gender and DRGs were \$4M less in aggregate in first 25 months (cross-sectional)
- Decreased mortality rate for CHN vs. Non-CHN patients (statistically significant)
- 69 days longer to readmission for CHN vs. Non-CHN patients for all APR-DRGs, full quartile (statistically significant)
- Significantly more CHN members navigated to Hospice and Home Health
- Wellness without Walls, targeted, place-based (zip code 38109) population health management efforts in 2010-2012 yielded 8.9 % decrease in charity care vs. 30.8 % increase from 2010 baseline

Barnes PB, Cutts TF, Dickinson SB, Hao G, Bowman S and Gunderson G. Methods for Managing and Analyzing Electronic Medical Records: A Formative Examination of a Hospital-Congregation Based Intervention. *Population Health Management*, 2014 May 27. [Epub ahead of print]. PMID:24865595.

Cutts, Teresa. "The Memphis Congregational Health Network Model: Grounding ARHAP Theory " In *When Religion and Health Align: Mobilizing Religious Health Assets for Transformation*, edited by James R. Cochrane, Barbara Schmid and Teresa Cutts. Pietermaritzburg: Cluster Publications, 2011.

[Thompson, MP.](#), [Podila, PSB](#), [Clay, CBCC](#), [Sharp, J](#), [Bailey-DeLeeuw, S](#), [Berkley, AJ](#), [Baker, BG](#), [Waters, TM](#). *The American Journal of Managed Care*, February 2018, Volume 24, Issue 2
Feb. 2018.

The Methodist North and CHN Case Study: 2009

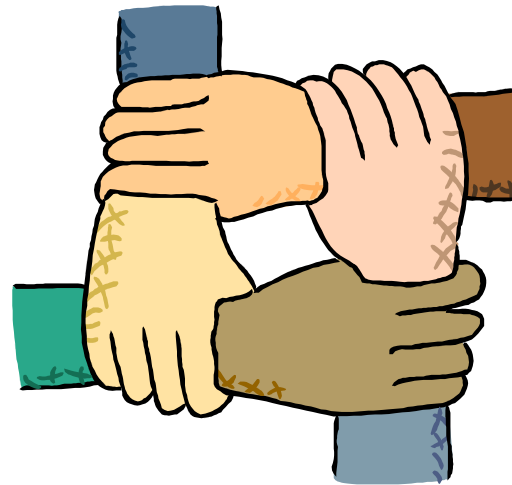
RWJF Aligning Forces for Quality EQUIC Project

Standardized R/E/L Data Collection

- Jan-2010: Standardized data collection for race, ethnicity, language introduced at Methodist North
- Jan-2011: Process introduced at Methodist South
- 2012: Process introduced at Methodist Germantown and University
- 2013: Process is system wide

Lesson learned:

In response to patient feedback, add option for bi-racial/multi-racial



AF4Q Cardiac Data Makes Visible

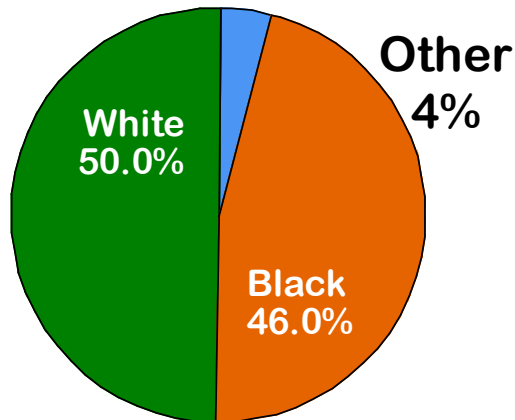
Good News: MLH North met and surpassed ideal care goals for Congestive Heart Failure (96%) and AMI (100%) cardiac measures once patients made it to the hospital—top of the competition.

Lessons Learned: Equity in clinical measures of ideal care can be reached by focusing on processes that ensure consistent delivery of evidence-based care measures for 100% of all patients regardless of race, ethnicity, or language preferences. **However, *our data surfaced other egregious disparities***

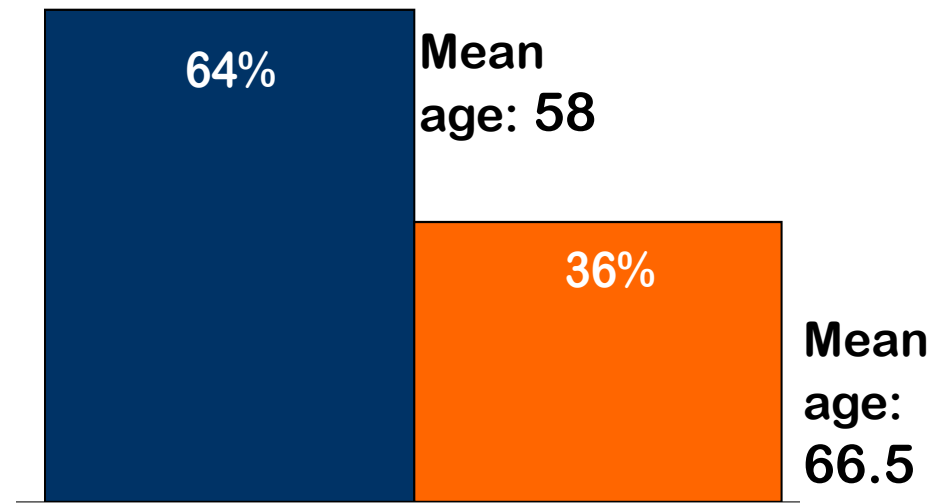
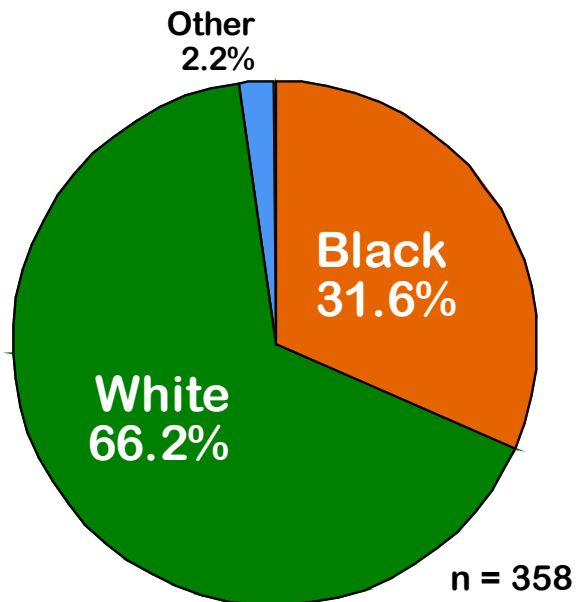
Bad News: African-Americans were dying of sudden cardiac death at twice the rate inside the ED or on the way to the ED vs. whites. Readmissions were lower than for whites. What was accounting for this disparity?

Pre-hospital Sudden Death

Methodist North Demographics



Inpatient AMI Volume



ED Deaths



N=116

Methodist North data, Jul-2009 to Aug-2010

Community Led and Initiated

HUGE Disconnect initially between Health System Values and Metrics and those of the Community

CHN Leaders and Faith Community Leaders Demanded Action on the part of the Health System



Build Long-standing, Humble Relationships (be a teachable HS)

- Supported by the Humble Leadership of CEO Gary Shorb, who allowed transparent sharing of all the data, even “dirty laundry”
- Series of meetings held, dialoguing about disparity “elephants in the room”
- CHN Liaison council allowed access to broader CHN liaison group (N=75) to share data and discern why African Americans were dying at higher rates enroute or in ED

Authentic Honoring of Community Intelligence, Capacity and Agency

- Listening with follow up actions based on feedback
- Embedded, trusted researcher/evaluator/observer was part of the integrated team
- Offer resources truly valued by Community Partners
 - CHN pastors put on MLH Board
 - Covered up to 60% out of pocket health costs
 - Created CHN Academy (now 28 8-week classes strong), all designed based on community input

CHN or Community Intelligence

- Minority distrust of hospitals, so patients reluctant to access services
- Lack of healthcare coverage/funds
- Hopelessness regarding future health status
- Lively interactive and educational discussion from community members about:
 - Best practice medications that differ from white (majority) populations studied in most large scale research trials
 - Issues around medication side effects in male patients
 - Differences in prodromal and presenting symptoms for AMI in African American and Hispanic women

Be Thoughtful and Conversant in Multiple “Languages” across Key Stakeholders

Language used can empower community or erode trust

- Translate traditional health system language in ways that are respectful and build and/or maintain trust
 - *“We all have an issue with our African American brothers and sisters dying at twice the rate of White persons. How can you teach us how to do better? How can we change this together?”* vs. “Your community members are dying faster than the white majority,” — more bad news.
 - *“Faith work in the congregations is saving lives”* vs. “gross mortality rate is halved due to network involvement”
 - *“Boots and Brains on the ground”* vs. just “Boots”
 - *“Under-liberated”* vs. “under-served’ communities
 - Conducted community health asset mapping for Hispanic health seekers in their primary language



Partnership Work

- Paula Jacobs and Quality Team shared information with medical staff, especially about best practice medications with minority patients
- Primary community input integrated in work with CHN, Case Management, Nursing Education, and other staff to , create culturally sensitive, low literacy Teach Back Tools for preventing Heart Failure and AMI, for use upon discharge of patients
- Changed our Chronic Disease and CHW courses to incorporate these materials (co-branding); stress need to go to the hospital sooner with acute Sxs

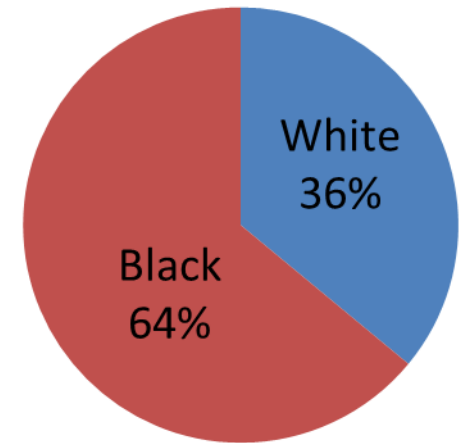


DID WE MAKE AN IMPACT?

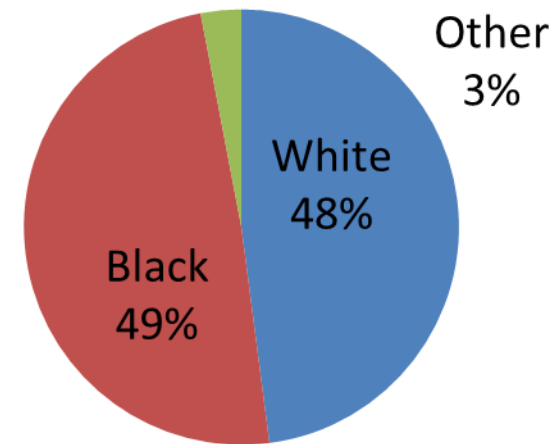
Did our combined efforts make an impact on survival odds for African-Americans in Memphis at our Methodist North Hospital? **YES!!!**

At baseline, African-Americans were disproportionately likely to experience sudden death outside of the hospital relative to the racial demographics of our patient population (MLN overall patient demographics were White=50%; Black=46%; Other=4%). This trend held true 2009 until Jan. 2012, when African-Americans dying at disproportionate rates slowed....

Period Jul-2009 to Aug-2010



Period Jan-2012 to Jun-2012



Partnership Work Continued

- Changed System Bioethics Committee to become “Ethics and Equity” Committee
- MLH Intensivist Dr. Sunny Anand and his team explored similar trends in Hispanic infants and children in the Methodist Le Bonheur NICU and PICU and decreased the disparity

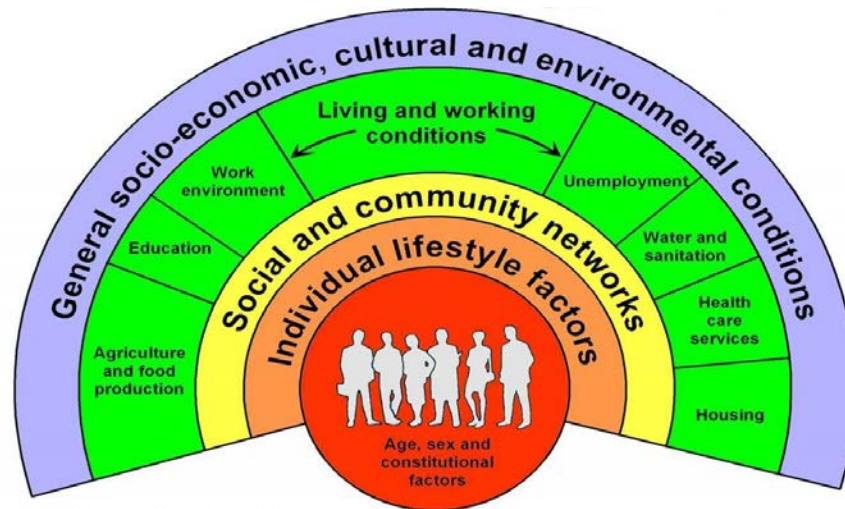
Anand, KJS, Sepanski, RJ, Giles, K, Shah, SH, Juarez, P. Pediatric Intensive Care Unit Mortality Among Latino Children Before and After a Multilevel Health Care Delivery Intervention *JAMA Pediatr.* 2015;169(4):383-390. doi:10.1001/jamapediatrics.2014.3789
Published online February 23, 2015.



Dr. Sunny Anand, Professor of
Pediatrics, Anesthesiology,
Perioperative & Pain Medicine at
Stanford

Measurement Assumptions

Social Complexity = Life exists within the interconnected web of systems and relationships that shape the social and physical contexts in which we live, but, like Community Power,
it is MESSY to measure....



Source: Dahlgren and Whitehead, 1991

Evidence/Measurement

Dynamic, Interactive Process

- Traditional tools and metrics are not adequate; need creativity, mixed methods
- Iterative learning cycles and formative evaluation are key (e.g., Plan-Do-Study-Act cycles, other models that help refine processes and programs)
- Non-extractive. Creating, building, measuring, analyzing, and feeding back data to **community partners' for their interpretation** continually. Community controls/crafts own data narrative.
- Building trust and the Integrity of the work/program is more important than rigor of design or metrics

Aim for Metrics:

- Easily captured and used to make specific changes in program delivery in short learning cycles
- Lead to quicker policy changes
- Appeal to all stakeholders and are value added for ALL

Good health outcomes/decreases in health disparity are artifacts of community power being deployed.

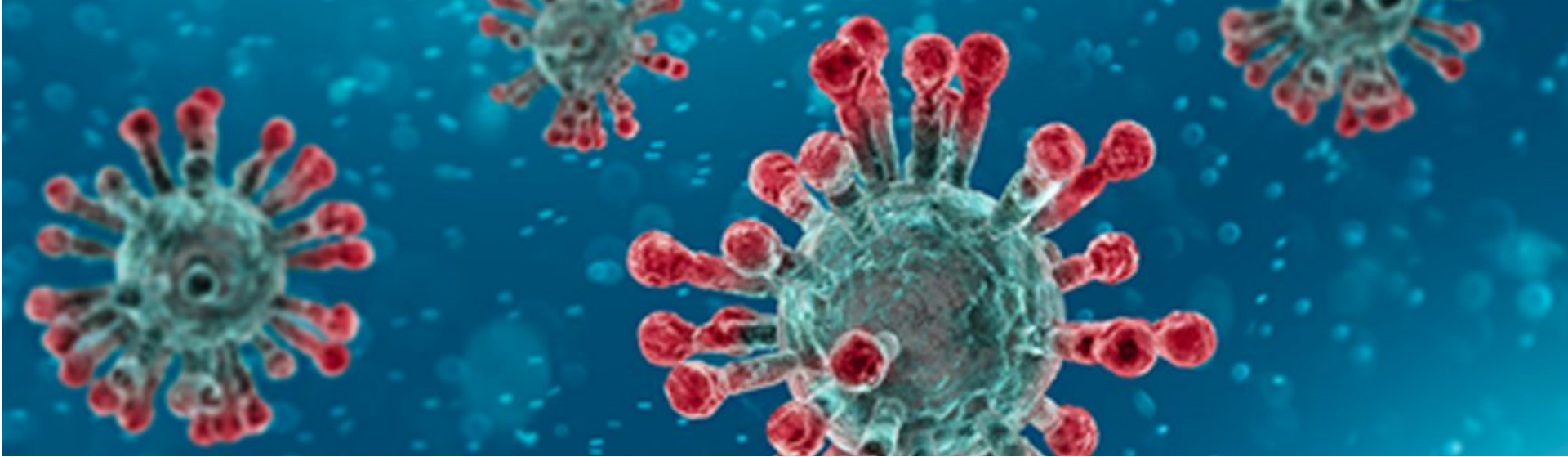


tcutts@wakehealth.edu

336.713.1434 or
901.643.8104

THANKS!!!

Thanks to Gary Gunderson,
Paula Jacobs and Kirsten
Peachey for use of slides



Community Empowerment and Health Equity: Practicing community-based participatory research (CBPR) in the time of COVID

Laura Chanchien Parajón, MD, MPH

Population Health Improvement Workshop

January 29, 2021

*The National
Academies of*

SCIENCES
ENGINEERING
MEDICINE

Community-based participatory research (CBPR)

A map for health equity

CBPR Definition

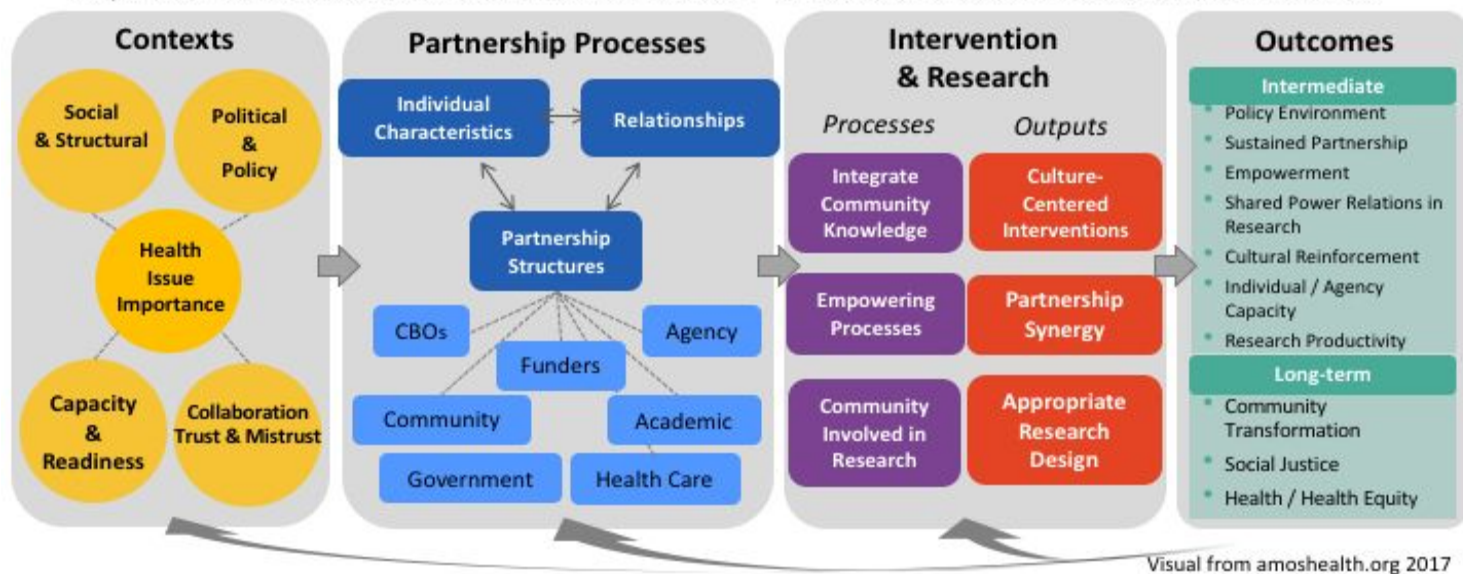
Collaborative efforts between multi-sector stakeholders who gather and use research and data to build on the **strengths and priorities** of the community and use multi-level strategies to improve health & social equity.

---Wallerstein, Duran, Oetzel, Minkler, 2018

CBPR Conceptual Model

Adapted from Wallerstein et al, 2008 & Wallerstein et al, 2018:

<https://cpr.unm.edu/research-projects/cbpr-project/cbpr-model.html>



Contexts	Partnership Processes	Intervention & Research	Outcomes
- Social-Structural: Social-Economic Status, Place, History, Environment, Community Safety, Institutional Racism, Culture, Role of Education and Research Institutions - Political & Policy: National / Local Governance/ Stewardship Approvals of Research; Policy & Funding Trends - Health Issue: Perceived Severity by Partners - Collaboration: Historic Trust/Mistrust between Partners - Capacity: Community History of Organizing / Academic Capacity/ Partnership Capacity	Partnership Structures: - Diversity: Who is Involved - Complexity - Formal Agreements - Control of Resources % Dollars to Community - CBPR Principles - Partnership Values - Bridging Social Capital - Time in Partnership Individual Characteristics: - Motivation to Participate - Cultural Identities/Humility - Personal Beliefs/Values - Spirituality - Reputation of P.I. Relationships: - Safety / Respect / Trust - Influence / Voice - Flexibility - Dialogue and Listening / Mutual Learning - Conflict Management - Leadership - Self & Collective Reflection/ Reflexivity - Resource Management - Participatory Decision- Making - Task Roles Recognized Commitment to Collective Empowerment	Processes - Integrate Community Knowledge - Empowering Processes - Community Involved in Research Outputs - Culture-Centered Interventions - Partnership Synergy - Appropriate Research Design	Intermediate System & Capacity Outcomes - Policy Environment: University & Community Changes - Sustainable Partnerships and Projects - Empowerment – Multi-Level - Shared Power Relations in Research / Knowledge Democracy - Cultural Reinforcement / Revitalization - Growth in Individual Partner & Agency Capacities - Research Productivity: Research Outcomes, Papers, Grant Applications & Awards Long-Term Outcomes: Social Justice - Community / Social Transformation: Policies & Conditions - Improved Health / Health Equity

CBPR Model

Context

Partnership

Intervention
Programs/
Research/
Evaluation

Health/
Social
Justice
Outcomes

E2

Engage for Equity

A National Study of Community
and Academic Partnerships



Tools from Engage for Equity

<https://engageforequity.org>



The screenshot displays the homepage of the Engage for Equity website. At the top, there is a navigation bar with a search box labeled "Search this website..." and three orange buttons: "CBPP Models", "Tools", and "E2 Evidence". Below the navigation bar is a large banner image showing a group of people gathered around a table in front of a white mobile health unit. The unit has the text "COMBINING KNOWLEDGE AND ACTION FOR SOCIAL CHANGE" and "mobile health unit" on its side. A yellow call-to-action box at the bottom right of the banner reads: "WANT TO KNOW MORE ABOUT YOUR PARTNERING PRACTICES?". The Engage for Equity logo is visible in the top left corner of the banner area.



“A **dialogue process** in which passive subjects become **participatory** actors.” (Freire, 1970).

Paulo Freire: Empowerment

CBPR Model



Practical Application of CBPR

In the time of COVID



SETTING

Large Congregate Shelter for
People Experiencing Homelessness

Shelter Transportation and Dormitories



CORONA CRUSHERS:

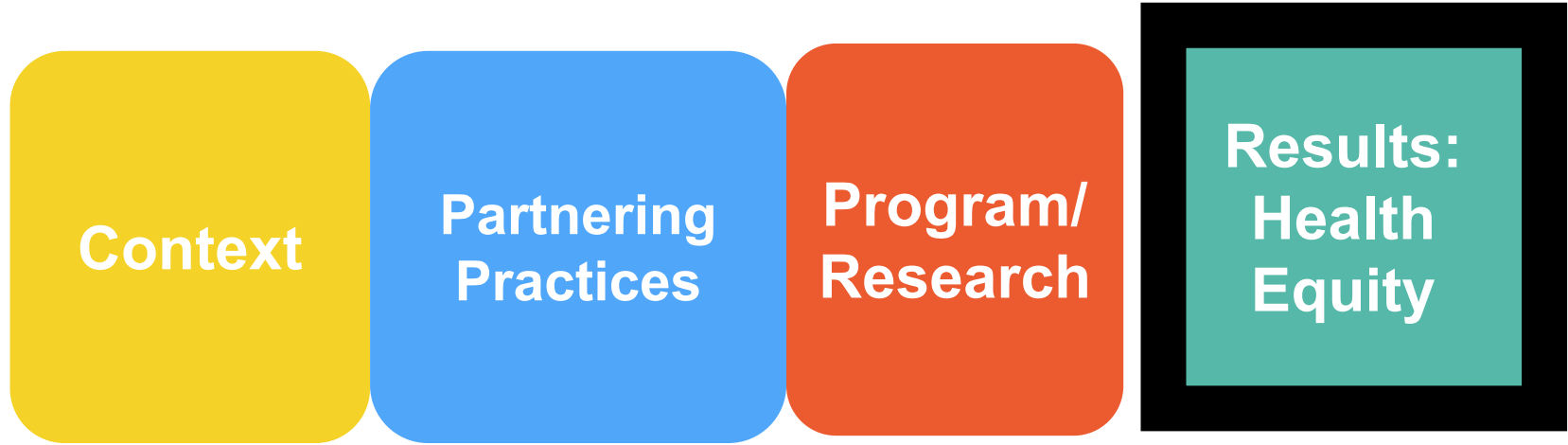


Community-coalition-based COVID-19 prevention and response:
a "whole community response"



- City of Albuquerque
- Local and state health departments
- University of NM: Students, Staff
- Medical Reserve Corps
- Outreach teams and street medicine providers (AHCH, FN)
- State and City EOC
- Healthcare providers
- CHWs
- Shelter Staff (Heading Home)

Start with Identifying Outcomes for Health Equity



Reduce the spread COVID 19 for People experiencing homelessness who do not have homes where they can self-isolate

OUTCOMES

What does the community we are working with want to achieve?

Intermediate and Long Term Outcomes

Empowerment outcomes

Outcomes

Intermediate

- Power sharing through greater community power
- Sustained Partnership
- Policy change in universities and community to foster empowerment
- Individual/Agency Capacity

Long-term

- Community Transformation
- Improved health (i.e. decreased COVID, etc.)
- Health / Health Equity (improved access, everyone with COVID immunizations)

CONTEXT

Context

Partnership

Program

Result:
Health Equity

Exposed and at risk

BY ELISE KAPLAN / JOURNAL STAFF WRITER

Published: Saturday, March 14th, 2020 at 10:18pm

Updated: Sunday, March 15th, 2020 at 12:05am

[f](#) SHARE

[t](#) TWEET

[in](#) LINKEDIN

[e](#) EMAIL

[p](#) PRINT

[s](#) SUBSCRIBE

MORE INFO:

- New Mexico restricts nursing home visitors
- Q&A: Novel coronavirus
- Full coverage: Coronavirus in New Mexico



has been homeless since he moved to Albuquerque in 2017, stains his bike with

Issue of Importance

Social/ Structural Inequities

Congregate Nature of Shelter Life:
Can't self isolate

Policy and Politics

Support for PEH,
WEHC, AHCH
Gateway Center

PEH:
Higher rates of illness,
co-morbidity

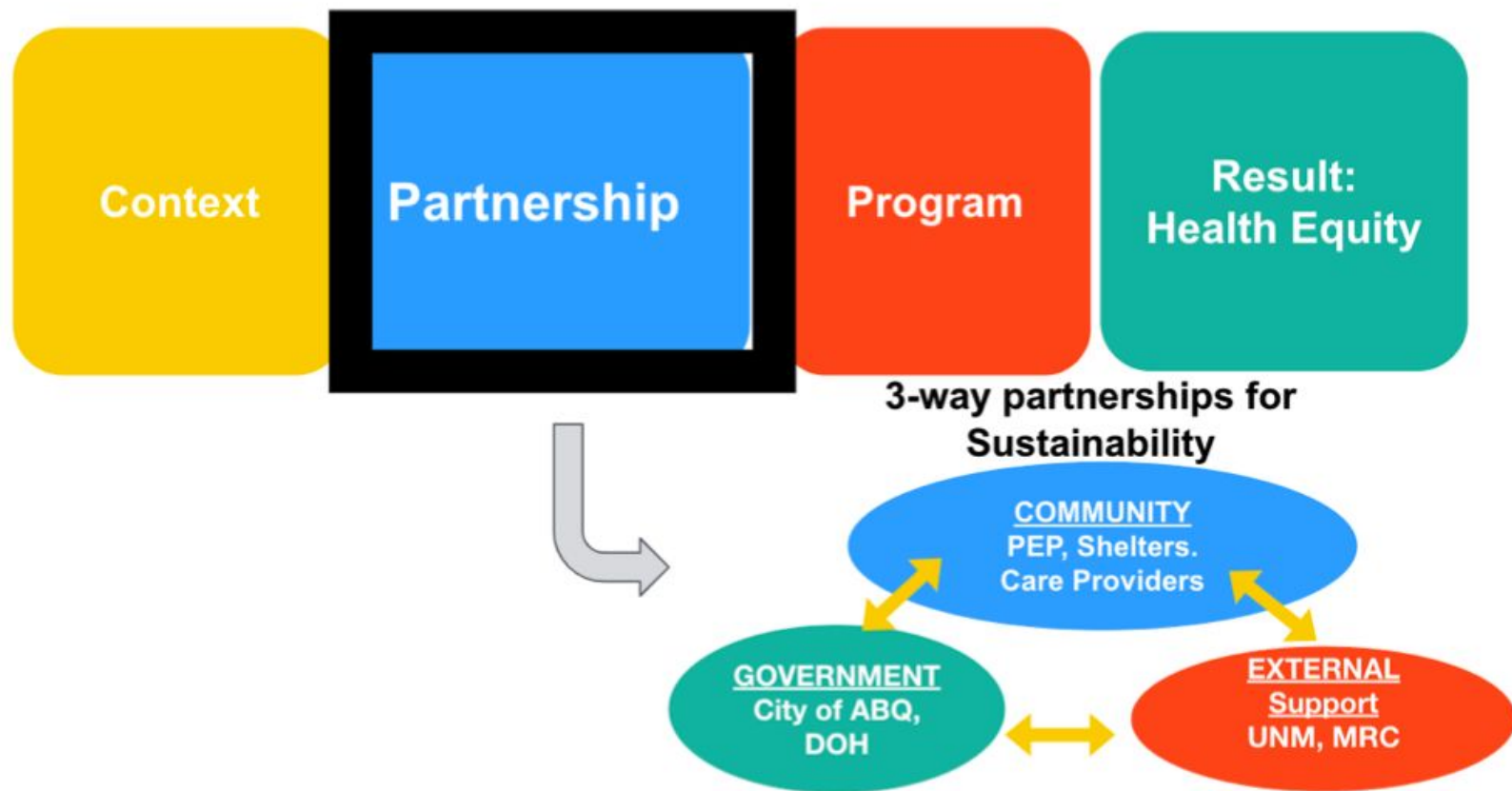
Capacity, Community Strengths & Readiness to Partner:

Capacity in City of ABQ,
MRC,
UNM, AHCH, FN,

History of Trust & Collaboration

Working together
for 1 year with
bi-monthly mtgs

COLLABORATION



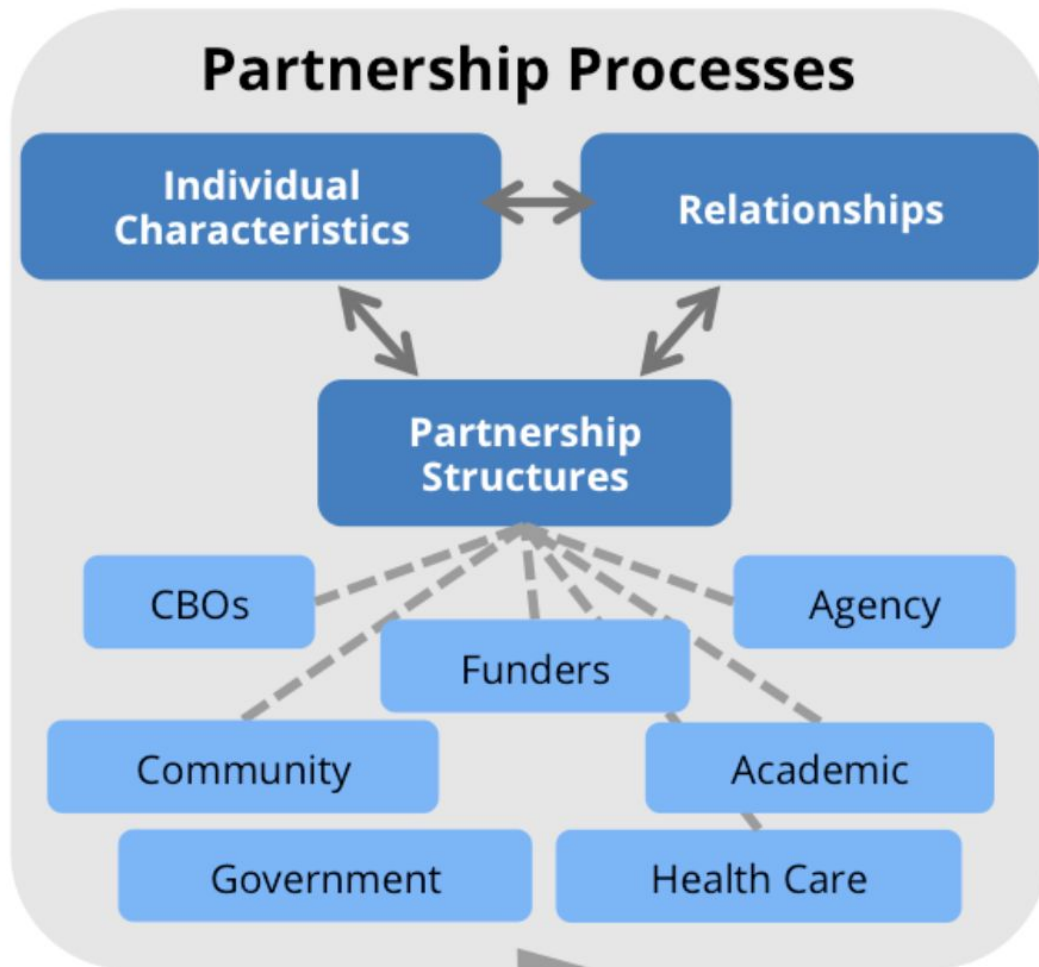
PARTNERING PROCESSES

Partnership Matters

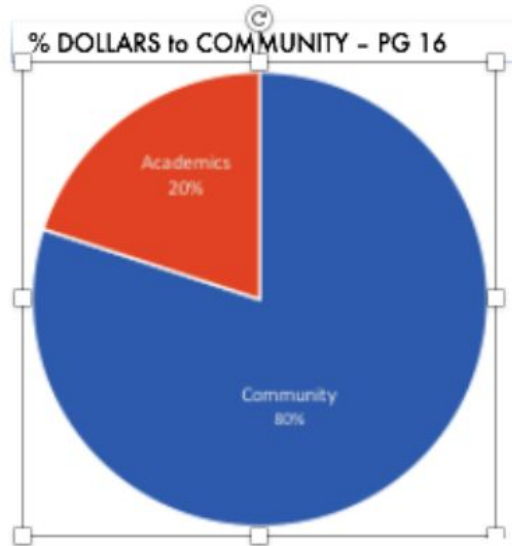
Who we are matters.

How we relate to one another matters. *Deliberate communication integrating community knowledge and fostering trust*

How our partnership is structured matters. *Structures that facilitate equity in in power.*



Partnership Data Report



FINAL APPROVAL - PG 13

Community/Tribal IRB ☐

Community Agency ☒

Community Advisory Board ☒

Local Government / Public Health Agency ☐

Individual / None ☐

CONTROL of RESOURCES - PG 15

	Mostly Academic	Both	Mostly Community
Control of Resources:		✓	

Emergency COVID19 Response: March 12th, 2020 - present

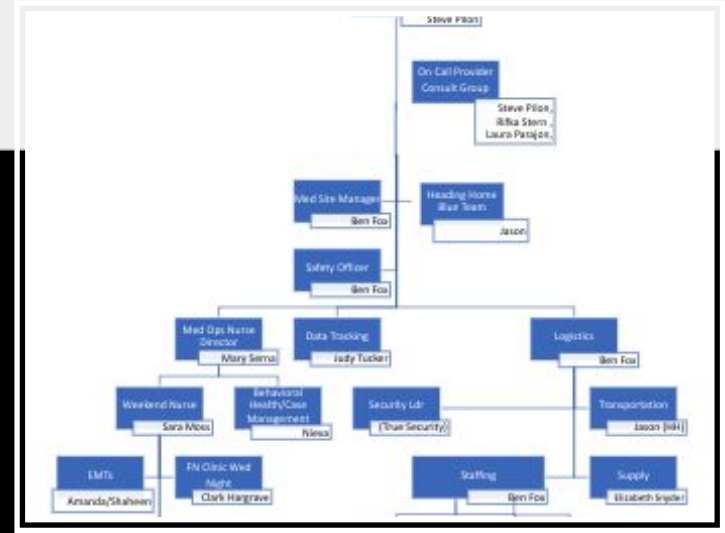
Deliberative Communication: LISTENING and PARTICIPATION

- **Daily Coordination** meetings led by City of ABQ: partnerships with Heading Home, AHCH, FN, UNM, Pres, DOH, County, MRC
- **Daily Coordination** of Medical team of healthcare for homeless providers during COVID 19
- **Co-Development** of medical pathways, volunteer call system and medical coverage, testing sites, and isolation pods
- **Fostered Trust, Built Community, Facilitate Equity, Power**

Multiple agency organizational chart

Facilitate EMPOWERMENT

- Clear roles and responsibility
- Leadership
- Participatory Decision Making
- Resources Management
- Formal Agreements
- Partnership values
- Partnership structures that fostered equity balanced with clarity of roles



PROGRAMS

HOW we do things is just as important as **WHAT** we do

Our Teams worked alongside shelter staff and CHWs

Empowering practices: How are we building capacity?

How are we integrating local knowledge and data to improve practice?



5 Key Elements of COVID19 Collaborative Response for PEH

1. Screening and Testing:

- [Screening \(Temperature/Symptoms\)](#)
- Testing and Isolating Symptomatic People and Contacts of COVID +

2. Isolation:

- Hotels for Individual Isolation

3. Social Distancing:

- Decrease Density of Homeless Shelters (Wellness Hotel)
- 6 ft distance or more (bed spacing, staggered mealtimes and social times) and face coverings

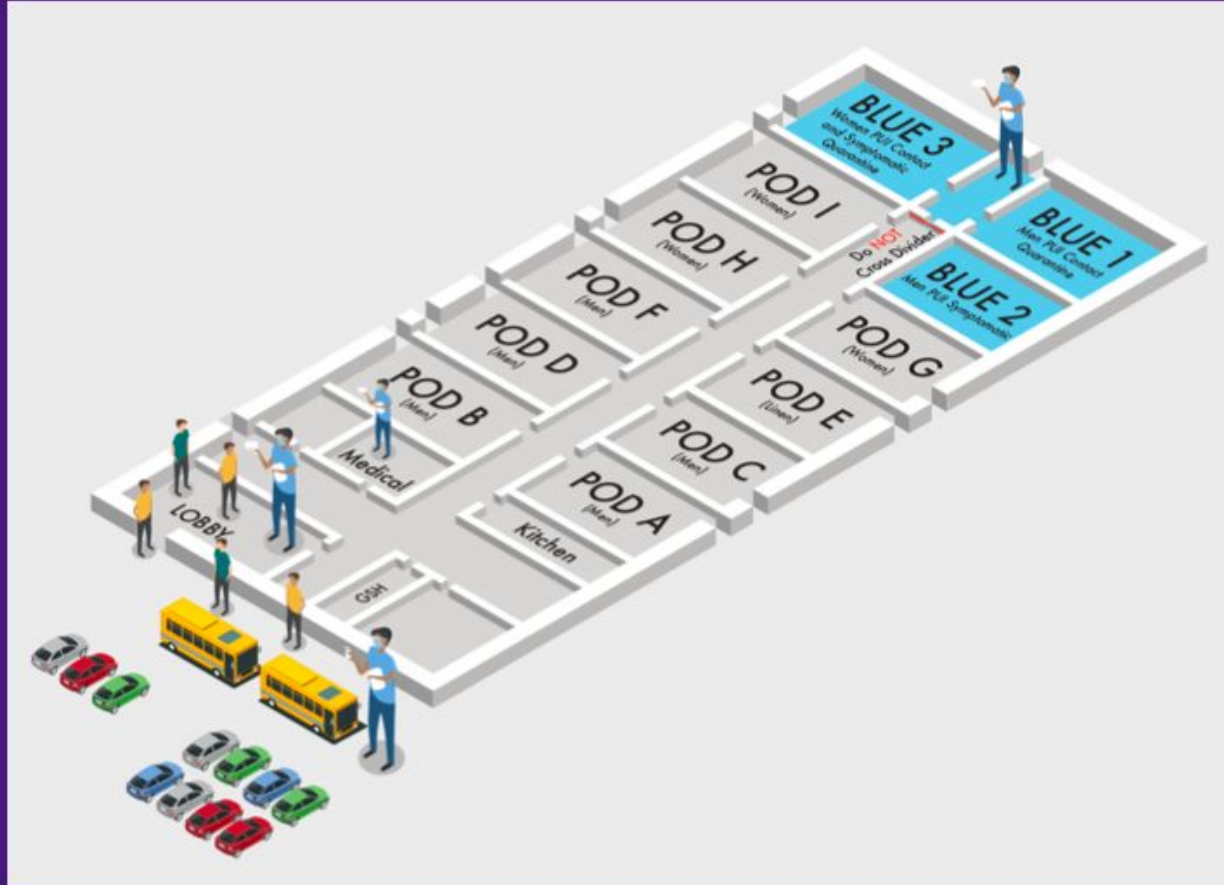
4. Early Medical Care with Collaborative Medical Care Model

- Care and Support of COVID+: monitoring, signs of danger recognition

5. Partnership:

- Daily coordination calls, Clarity of roles, clear communication, effective dialogue, trust

Quarantine and Isolation Area



Quarantine Pods

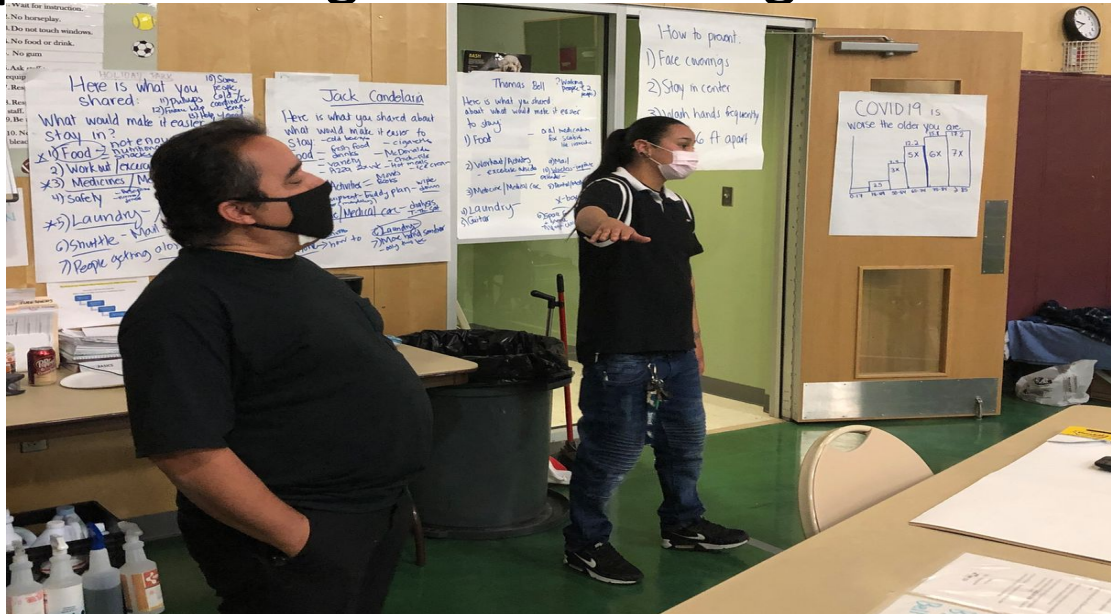


General Pods



Co-Learning Processes: Analyzing Community

Data on Barriers and Facilitators for Sheltering in Place
→ Improved Program Reflecting Community Priorities



Iterative improvements: from shelters to wellness hotels



Shelter Setting



Community Center Setting:
6 Feet Apart



Wellness Hotel

STAFF TRAINING: PPE

WHAT PROTECTION DO **YOU** NEED?

Residents and Regular Pod Staff:

Handmade
Face Covering
Or Bandana



Residents **with Cough**:

Surgical Mask



Registration Staff:

Surgical Mask

Gloves



Drivers for Blue Pod
Daily Temperature Staff:
Blue Pod Staff:
Medical Staff:

Surgical Mask

Gloves

Goggles



Medical Staff
Doing COVID19
Tests:

Gown

N95 Mask

Gloves

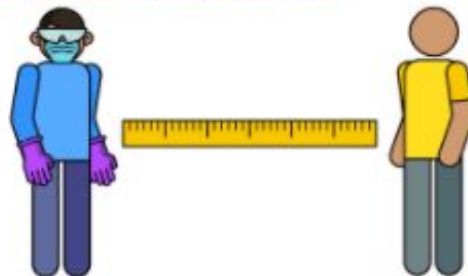
Goggles



Remember to always keep a safe distance from other people!

BLUE POD STAFF PROTOCOL

Never get closer than **2 arm lengths** (6 feet)
away from patients or other staff



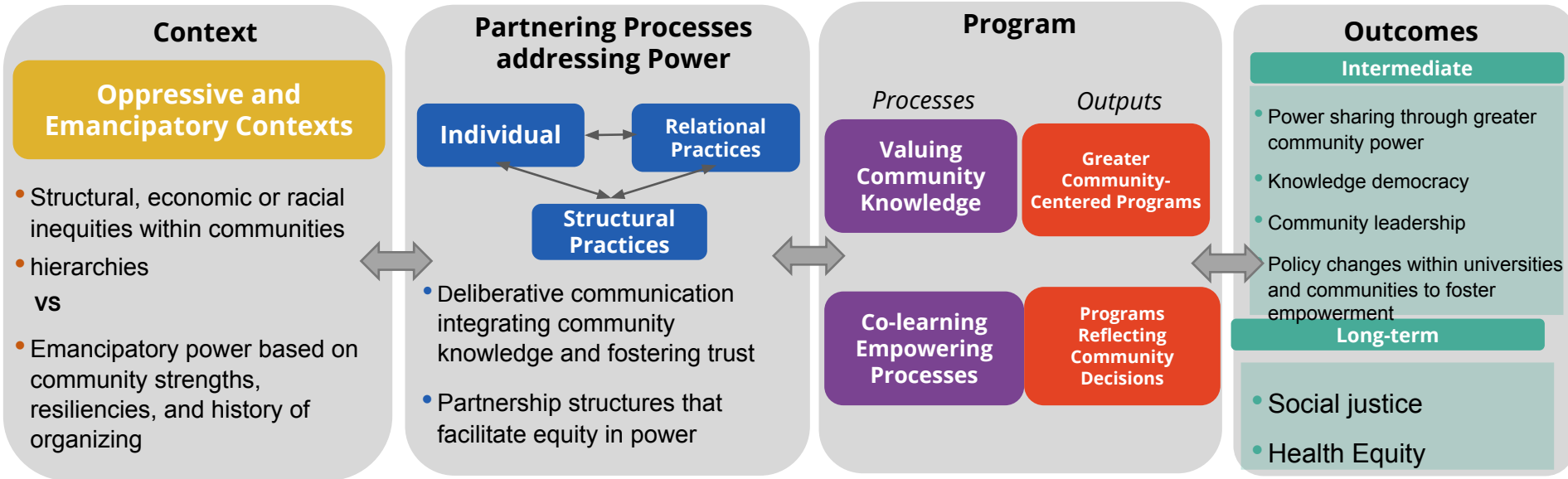
You must wear:

1. **Surgical Mask** (changed once a day)
2. **Gloves** (changed every shift)
3. **Goggles** (clean everyday and keep in brown paper bag for next shift)



Impact of Empowering Practices

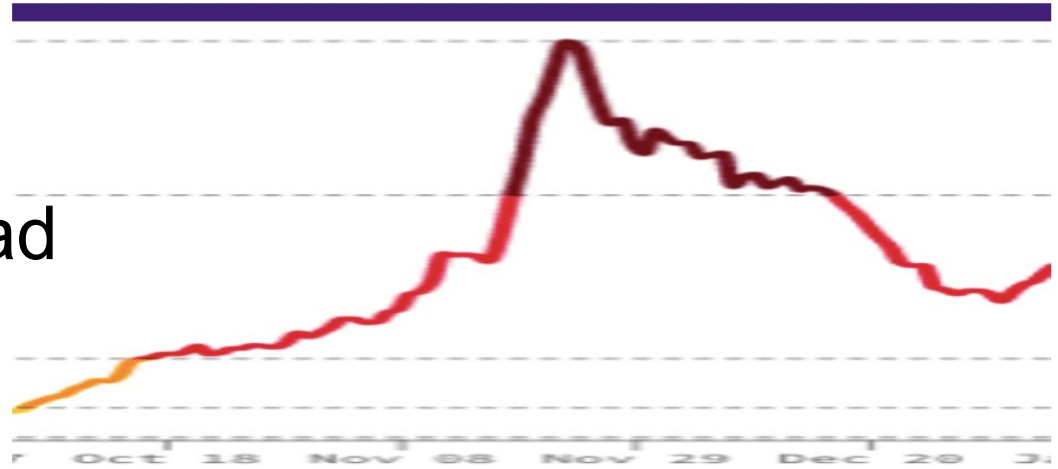
Empowerment and CBPR



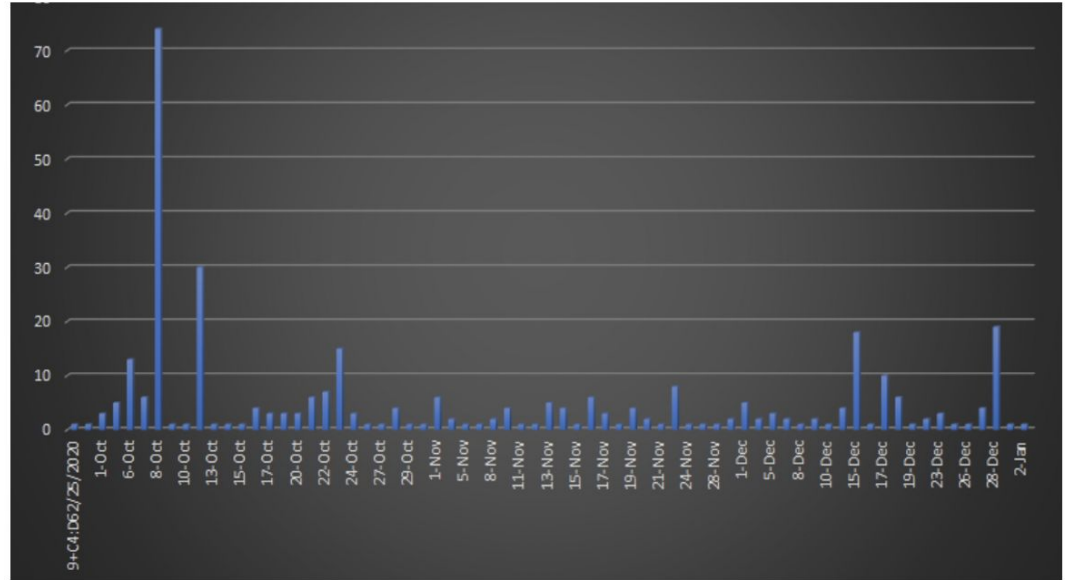
Wallsterstein, et. al. Power Dynamics in CBPR: A Multiple-Case Study Analysis of Partnering Contexts, Histories and Practices; Health Educ and Behavior. 2019. Oct: 46;

IMPACT #1: Reduce COVID Spread

Background rate of
COVID



Rate of COVID in Shelter



Impact #2: Alignment of Efforts Through CBPR And Community Leadership



Impact #3: Develop of New Protocols Together → Policy Change for Rapid Testing in Shelters



Impact #4: Build Capacity Together

Project	Impact
Barrier analysis survey on facilitators and barriers to sheltering in place for seniors experiencing homelessness	Increased sheltering in place from 25% to 75%; action plans for improving conditions for sheltering in place
Fundraising to provide items needed by seniors for sheltering in place	Provision of supplies, snacks, essential care products, socks, underwear for supporting sheltering in place for seniors
Development of graphics, Logo for Corona Crushers Team Building	Corona Crushers t-shirts for all partners in COVID19 response to build community
Shelter Staff Training: Training materials on COVID and PPE for Shelter Staff	Development of COVID19 Training Materials for Shelter Staff with Training of over 80 Shelter Staff
CHW Training Support: Graphics, Research on Topics, Translation of Trainings from English to Spanish	Visually appealing training materials Spanish Translation of Materials
Development of Protocols, Policies, and Trainings For COVID	Policies for Jails; Expedited Referrals from ER; Call System
Development of Data Collection System for COVID Care	Data visualization used to make policy decisions

1. ANALYZE CONTEXT

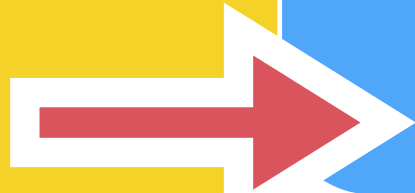
A yellow rounded rectangle with a thin black border, containing the word "Context" in white text.

Context

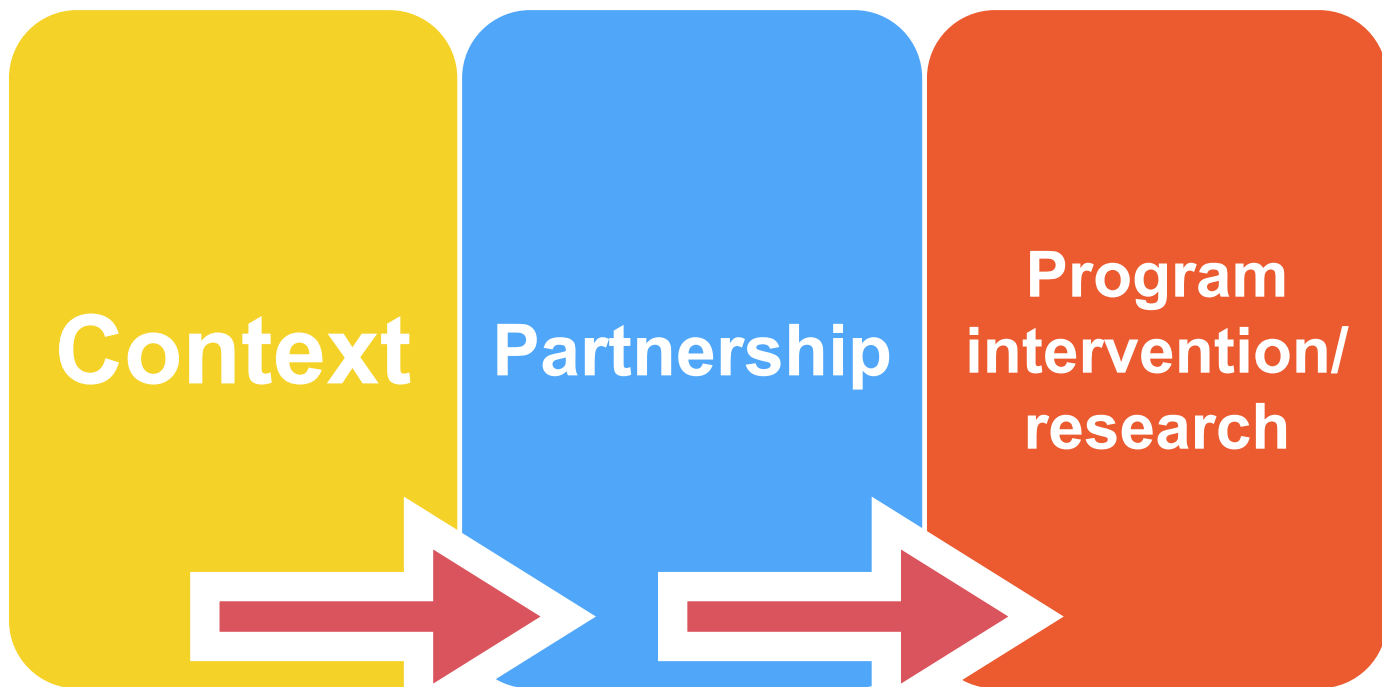
2. PARTNER WELL

Context

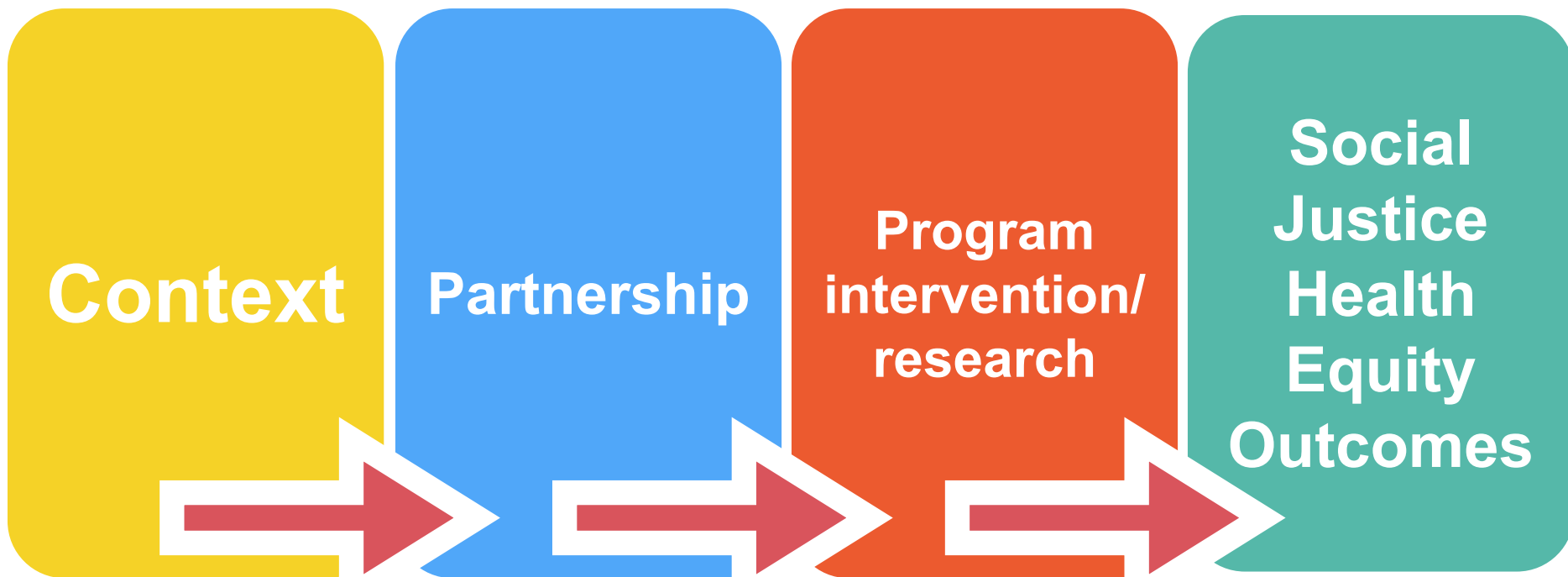
Partnership



3. EMPOWERING PROGRAMS BUILT ON STRENGTHS



4. HEALTH EQUITY OUTCOMES



A scenic landscape featuring a wooden walkway with metal railings that leads through a rocky, desert-like environment. The sky is a vibrant blue with scattered white clouds, and a faint rainbow is visible in the upper right portion of the frame. The overall atmosphere is peaceful and inspiring.

SHOW UP

BE WHO YOU ARE

LISTEN, LISTEN, LISTEN

BELIEVE IN SOCIAL JUSTICE

TAKE ACTION FOR CHANGE

-Mary Northridge, 2003

Acknowledgements

City of ABQ Team: Carol Pierce, Doug Chaplin, Myra Segal, Bobbie Sisneros, Lisa Huval, Judy Tucker, Elizabeth Snyder, and many other City of ABQ staff

Heading Home Team: Dennis Plummer, David Sisneros, Levi Chavez, Blue Team, Blue Team Screeners

Shelter Medical Team: Steve Pilon, Ben Fox, Mary Serna, and EMT Team, Rifka Stern, Brian Solan, Ruth O Keefe

Hotel Teams: Catherine Elliot, Ric Traeger, Rippy Williams, Tara Cuning, Luke Esquibel, Site Managers, Cristina Parajon, and all MRC Volunteers Supporting the Hotel

State and Local DOH: Chris Novak, David Selvage, Margaret Cunningham, Heather Black, Marla Seivers

Albuquerque Health Care for the Homeless Team: Nadia Fazel, Rachel Biggs, Sara Doorley, Jenny Metzler

First Nations: Rachel Murphy, Marsha Souers

Presbyterian: Elizabeth Holguin, Sharon Thompson

UNM Pathways Team: Venice Ceballos, Virginia Sedore, Myra Perez, and all our Pathways CHWs

CYFD State Team: Janice Chino-Acton, Brian Blalock, Anisa Goodman, Michael Burgess

UNM HSC Team: Rodney McNease, Jessica Kelly, Chamiza Pacheco de Alas, Kelly Camden, Crystal Franz

Medical Students, Public Health Students, Undergraduate Students, Family Med and Prev Med Residents: Nate Birnbaum, Nhu Do, Julia Rauchfus, Rory Auderheide, Graemme Chiason, Davey Parajon, Scotty Parajon, Jamie Madji

Corona Crushers Community Health Engagement Block Team and Corona Crushers Med Student Team

Vanna Cochran, Emma Hart, Monica Moyash, Carrie Zografos, Lindsey Hancock, Jawaher Assed

Jessica Nelson, Vanna Cochran, Brenna Banwarth-Kuhn, Emma Wolinsky, Donovan Chase the Bear, Erika Baca, Talmage Brown, Kaleb Stevens, Kitty Foos, Michael Miera, Caroline Muraida, Madeline Starkweather