

*Latino/Hispanic Health Equity Initiative:  
Achieving Health Equity Through  
Education, Collaboration & Action*

*Nuts and Bolts for Community Change*

*May 16, 2014*

# Welcome and Overview

- Welcome
- Symposium/Workshop Goals & Objectives
- Brainstorm & Group Discussion
- Building Collaborative Partnerships
- Community Action Planning
- Participant Guide

# Session Guiding Principles

- Be open-minded
- Participate fully
- Share space and avoid over-participation
- Be mindful of the meeting goals and objectives
- Engage in solution finding
- Minimize side bar conversation
- Be respectful of others ideas and opinions
- Please turn off cell phones and other electronics
- Avoid sharing confidential information
- Have fun!!

# Symposium Goals and Objectives

- To provide a forum where members of Latino/Hispanic communities can discuss, identify, and prioritize health disparities that impact their region;
- To provide a venue for lively and informative discussion among participants with wide ranging expertise to formulate specific policy recommendations that will address a regionally identified issue;
- To provide an opportunity for community stakeholders to provide substantive input on NYSDOH's response to addressing health disparities within the Latino/Hispanic community; and
- To leverage community resources through collaborative partnerships and alliances among multiple regional sector representatives for the subsequent development and implementation of Action Plans that will address racial and ethnic health disparities within the Latino/Hispanic community.

# Nuts and Bolts for Community Change

This workshop will provide an overview of the Community Action Plan (CAP) process and tools that can be used to identify issues, assess resources and capacity, and develop collaborative partnerships.

# Collaborative Partnerships

At the end of this workshop you will:

- Become familiar with a model that can be used for forming collaborative partnerships.
- Learn the key elements of forming a collaborative partnership.
- Have tools to help identify potential partners.
- Learn about ways to leverage resources.

# Community Action Planning

At the end of this workshop you will:

- Identify regional strategies and programs already in existence.
- Foster the development of innovative approaches to assist in the reduction of racial and ethnic health disparities.
- Provide participants with the tools to develop and implement a Community Action Plan.

## Why Are We Here?



### **Health Disparity:**

a difference in disease prevalence or outcomes

### **Health Inequity:**

a difference that is unnecessary, avoidable, unfair and unjust

### **Social Determinants of Health:**

the economic and social conditions that influence health



# Social Position Matters



- Income and education are markers of socioeconomic position
- Lower socioeconomic position results in worse access to healthcare
- AND social position influences
  - exposure to health opportunities and risks, and
  - resources to buffer health risks

# Place Matters



Where a person is on the social ladder determines whether a person is surrounded by things that make it easy or difficult to maintain healthy behaviors.

# Race Matters

- Racially based discrimination contributes to uneven distribution of income, education, neighborhood poverty, and access to health care.
- Racially based discrimination creates chronic stress and contributes to poor health whether or not you are poor, uneducated or uninsured.

# Stress Matters

- Chronic stress is toxic affecting physiologic processes that can trigger diabetes, asthma, and heart disease.
- People with lower socioeconomic position have higher levels of chronic stress—and fewer resources to deal with stress.

# In Short....

“Poorer people live shorter lives and are more often ill than the rich. This disparity has drawn attention to the remarkable sensitivity of health to the social environment.”

Source: **Social Determinants of Health, The Solid Facts. World Health Organization, 2003.**



# Brainstorm & Group Discussion

## *Report Back – (10 minutes)*

- Each small group should have chosen a note-taker and reporter at the beginning of the session. Responses should be recorded on newsprint provided.
- Reporter should present summary of key findings from the small group discussion.

# Disparity Focus

- For the purpose of this workshop the focus of discussion will be on obesity.
- Example of Small Group Discussion Worksheet.



# Question 1

- Are there specific programs you are aware of that have been developed in your region to address this issue?
  - If yes, what is the program and who is involved?
  - If no, who should be involved in addressing this issue?

## Question 2

- What are the top two barriers that exist to prevent the region from effectively addressing this racial and ethnic health related disparity?
  - List 2 strategies to overcome the barrier(s).
  - Who should be at the table to address these issues? Consider who is most affected based on nationality, age, country of origin, and immigration status.

## Question 3

- In light of today's discussion,
  - List two organizations, agencies, and leaders that should be involved to implement actions in order to address the issue of obesity in your region.

# Building Collaborative Partnerships & Leveraging Resources

# Rationale for Collaborative Partnerships & Leveraging Resources

- In 2010, 3,416,922 Latinos/Hispanics were living in New York State, representing the largest minority group in the state. It is projected that by 2025, Latinos/Hispanics will continue to grow by 150.1%. \*
- Latinos/Hispanics continue to show a higher incidence and prevalence rates of chronic and degenerative conditions when compared to other racial/ethnic groups. \*\*
- Environment of economic instability and budget deficits.

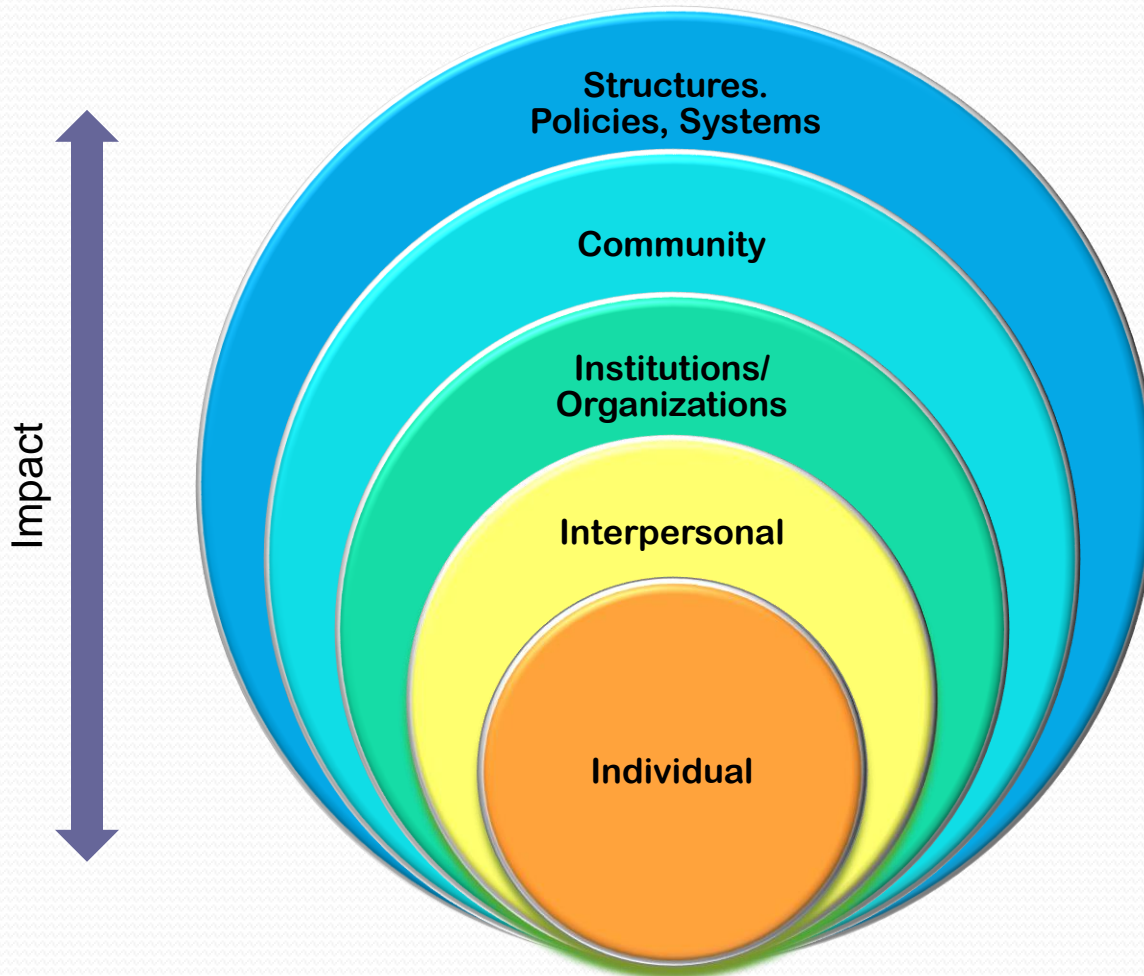
\* 2010 Census Report.

\*\* Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice*. (5<sup>th</sup> ed.). New York: John Wiley & Sons.

# What is Collaboration?

- The basis for bringing together the knowledge, experience and skills of multiple individuals to contribute to the development of a new program or initiative.
- It allows a group to accomplish what they could not accomplish individually.
- Enhances the capacity for mutual benefit and to achieve a common purpose.

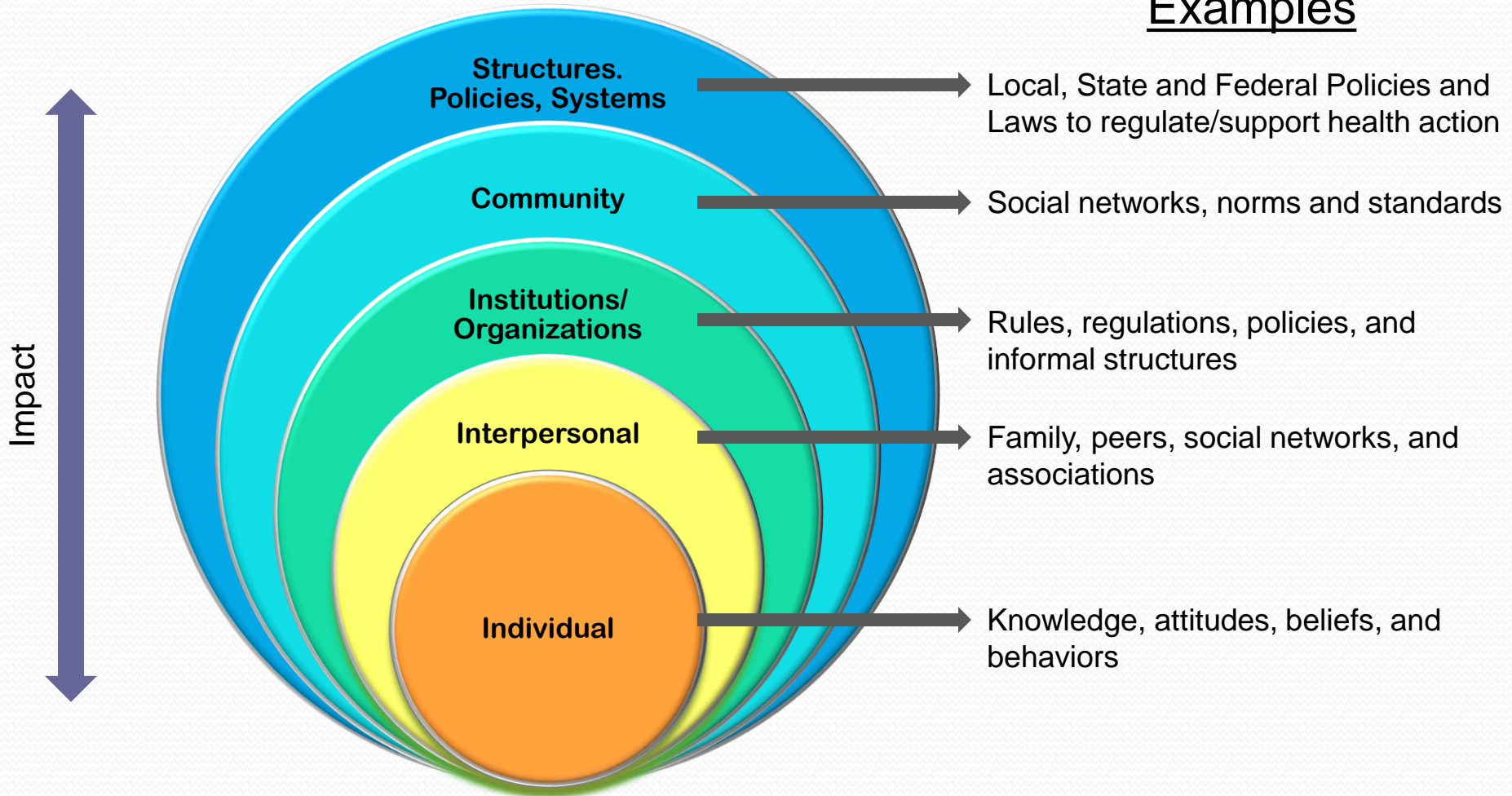
# The Social Ecological Model



**Depicts the relationship between health behaviors and individual, interpersonal, organizational, community, and social subsystems.**

# The Social Ecological Model

## Examples







# Question?

## Why Is Collaboration Important?

# Why Is Collaboration Important?

- Failure of existing efforts to address the problem (need for innovation).
- Identify gaps in current services and provide a means to fill the gaps.
- Develop a greater understanding of client and community needs by seeing the whole picture.
- Provide better services to clients/community via partner agencies.
- Recognition of mutual needs or purpose and shared responsibility for the problem as well as the solution etc.
- Scarcity of resources.
- Mobilize action to effect needed changes through collective advocacy.

# The Four Cs of Partnership

## 1. Communication

- Individuals come together to exchange information and resources.
- Emphasis is on tapping into other people for contacts, information, and identifying resources.

## 2. Cooperation

- Focus is on accomplishing a specific purpose or goal.
- Work is driven by individuals rather than the organizations they may represent.

Sweeney, Shawn (October 2011). *Leveraging Resources Through Community Partnerships*. ETA/ASTD Regional Technical Assistance Forum.

# The Four Cs of Partnership

## 3. Coalition

- More formal focus at the organizational level. Intent is to address a specific need and disband.
- The goal is to impact an issue beyond what one group could do alone.

## 4. Collaboration

- Formal and sustained commitment.
- Involves shared decision-making and allocation of resources.
- Work together to accomplish a common mission related to critical and complex social issues of broad concern.

# Think about your own partnerships. List the ones that fit into each category

- **Communication** – exchange information and resources.
- **Cooperation** – individuals (not organizations) work to accomplish a specific goal.
- **Coalition** – organizations work together to address a specific issue/need then disband.
- **Collaboration** – groups or organizations make a formal, long-term commitment to work together towards a common mission.

# Leveraging Resources & Selecting Partners

- Leveraging resources: combining existing and new resources to accomplish a goal, promote growth, and make more from what is available.
- Resources (It's More Than Just Money) can include:
  - Physical – buildings, tools, space
  - Financial – money and funding
  - Social – relationships between people, partners, equipment and space
  - Policy – i.e. Affordable Care Act, New York State of Health

Brown, Bettina L., Wagner, Judith O. 2005. *YouthWork Information. Brief No. 4 . Leveraging Resources, Learning Work Connection.*

# Leveraging Resources & Selecting Partners

## *Think Outside the Box*

- **Be Creative** - push yourself out of your comfort zone; try something different.
- **Think With An Open Mind** - listen to, support, nurture and respect others when they come up with new ideas.
- **Challenge Assumptions** - just because it has always been that way, doesn't mean that it has to continue to be that way.

# Leveraging Resources & Selecting Partners

## Things To Keep In Mind

- **Potential for Impact:** Is there real value that can come out of a partnership that couldn't be achieved on our own?
- **Common Values:** Is there sufficient commonality of values between the organizations to make a partnering relationship realistic and viable?
- **Good environment for partnering:** Are there external forces that persuade the organizations toward a partnering relationship. Is the timing right?
- **Consistency with each others goals:** Is the partnering relationship consistent with and supportive of each organization's mission?



# Who Should Be At The Table?

## Partnering Right


- Seek partners who represent a broad cross-section:
  - Education
  - Healthcare and human service providers
  - Business and political leaders
  - Civic organizations
  - Faith based organizations
  - Community stakeholders & leaders
  - Individuals directly impacted by the issue being addressed
  - City, State and Federal agencies

# Who Should Be At The Table? Cont'd

- Work with people who are willing to work together and who are willing to share information.
- Work with people who place a high value on the success and growth of the community.
- Successful partnerships are based on trust and shared interest.
- Make sure your partners reflect diverse perspectives, experiences, cultures and levels of influence and have decision making power.

# Don't Wait For **All** Partners To Get on Board

- Don't wait to move forward with your plans.
- Most partnerships expand gradually over time.
- As partners are identified and community embraces the idea for a partnership; the size and impact of the partnership will grow.



# Community Action Planning (CAP)



# Question?

What is a *Community Action Plan*?

# Community Action Planning

- A road map for creating community change by specifying what will be done, who will do it and how it will be done.
- Program outcomes, goals and strategies follow directly from the community assessment and visioning process.
- Goals, objectives, and strategies are building blocks to make sure that the desired outcomes are produced and hold each other accountable.



# Question?

## Why develop an Action Plan?

# Developing An Action Plan

## Why develop an action plan?

- To lend credibility to your organization/group -
  - *An action plan shows members of the community (including grant makers) that you are organized and dedicated to getting things done.*
- Don't overlook details -
  - *You want to ensure that your action plan is clear and comprehensive.*
- For feasibility - *to determine and understand what is/not possible to accomplish.*
- For efficiency - *to save time, energy, and resources in the long run.*
- For accountability - *to increase the chances that people will do what needs to be done.*
- Helps keep focus.



# Developing An Action Plan cont'd

## **A tool to,**

- reach consensus.
- measure impact.
- help organize and conduct activities in a systematic way.
- distinguish roles and processes.
- reduce conflict.
- identify needed resources.
- hold each other accountable.
- document.
- keep a record of activities.
- share with partners.

# How Do We Develop a CAP in Our Region?

- What do you want to accomplish?
- Why is the work necessary?
- What already exists?
- How do we proceed?
- By when (for how long)?
- Who should be involved? Consider who is most affected based on nationality, age, country of origin, and immigration status.
- Communication (who should know what? And how will they receive the information?)
- What resources are needed (money, staff, space)?
- Where will the work be done?
- How will we know we've succeeded?

# Toolkit

- Example of an Action Planning Worksheet (blank)
- Example of an Action Planning Worksheet to Address Obesity
- Stakeholder Identification Sheet (blank)
- Example of a Stakeholder Identification Sheet
- Technical Assistance Needs Sheet

# Next Steps:

- Final thoughts/ “aha’s” from workshop
- Evaluations



Thank You!!!

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