



# A TOOLKIT FOR COMMUNITIES



## WELCOME!

We're so glad you're here! Thank you for your interest in learning about Community Voices for Health in Monroe County (CVHMC).

In 2020, the Robert Wood Johnson Foundation awarded six grants to organizations across the country seeking to make transformative change in their regions related to community health. The goal of the CVHMC initiative, located in Bloomington, Indiana (Monroe County), was to design and test approaches that incorporate strong voice from marginalized groups in decision-making that affects health. This was a multifaceted and substantial project involving many cross-sector partners, including a significant number of local community members and leaders.

This toolkit is designed to assist anyone with an interest in improving decision-making in their community to make it more equitable, inclusive, and participatory. While our initiative was focused on health, the principles apply to virtually any decision-making or policy-setting process. In the following eleven sections, we describe how we designed the initiative and will highlight our efforts to meet people where they are. The intent was to bring together people who might not otherwise be heard in health-related policy decisions; therefore, at every step of the initiative, we considered issues of equity and inclusivity.

In the sections that follow, we share with you our experiences in striving to reach that goal. We discuss the significance of this work along with approaches that worked well and efforts that were challenging. Our hope is that, as you move forward with creating opportunities for your own community conversations, you may learn from our experiences, gather new ideas, and find ways to forge your own path in your work toward equitable and participatory decision-making in your community. At the end of each section, we've included some questions to prompt your thinking, and there are many resources available in the appendices.

Anyone with an interest in exploring such decision-making practices should find the contents of the toolkit useful. We hope the kit will be easy to use and serve as a valuable guide as you move forward with this vital work. For communities in Indiana, please plan to stay in touch. Others around the state are also working to build more equitable engagement practices and we can learn a lot from each other.

In good health!

*The Community Voices for Health in Monroe County team*

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We also wish to thank the Robert Wood Johnson Foundation for their vision and their commitment to improving equity in health-related decision-making. In addition to funding the initiative, they provided support and excellent technical assistance along the way that was invaluable.

Their vision is making the world a better place.



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*The Partners Council is a component of the CVHMC initiative, but operates alongside it, rather than within it. It provides a means of disseminating information and ideas from the initiative to other communities in the State of Indiana. The content of this toolkit is not representative of the views or activities of the Partners Council or its members.*

Accelerate Indiana Municipalities  
Association of Indiana Counties  
Bloomington Health Foundation  
Community Justice and Mediation Center  
HealthNet  
Indiana Minority Health Coalition  
Indiana University Bloomington (IUB) Center for Rural Engagement  
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*The views expressed here do not necessarily reflect the views of the Foundation.*

## Section II: Introduction

There are a few general concepts inherent in our work that are important to understand at the outset. First, our initiative is focused on decision-making that impacts health, and health is viewed in a very broad sense. This means being concerned not only with medical care, but also with social determinants of health such as food and housing security, community safety & support systems, employment/economic stability, education, neighborhoods and the physical environment (i.e., parks, playgrounds, transportation), systemic racism, and more.

Second, decision makers are people in a wide variety of roles and sectors who possess power that affects others. They can be hospital CEOs, parks department heads, directors of social service programs, elected officials, and so on. For the purposes of our initiative, we limited our scope to local government officials on executive and legislative elected bodies. In our community, that means the county council and board of commissioners, and the city council and mayor's office.

Third, regarding public engagement, we believe that community members are experts about local issues and the experiences in their lives. They have the power of lived experiences to help guide local decision-making in the ways that matter most. Integrating community voice into each stage of this work is the glue that holds it together.

“Working in silos is the biggest obstacle, so more partnerships, collaborations, and regional efforts are required to advance workable and sustainable solutions to community health problems and underserved access to healthy choices.”

*Final Elected Officials Survey, November 2022*

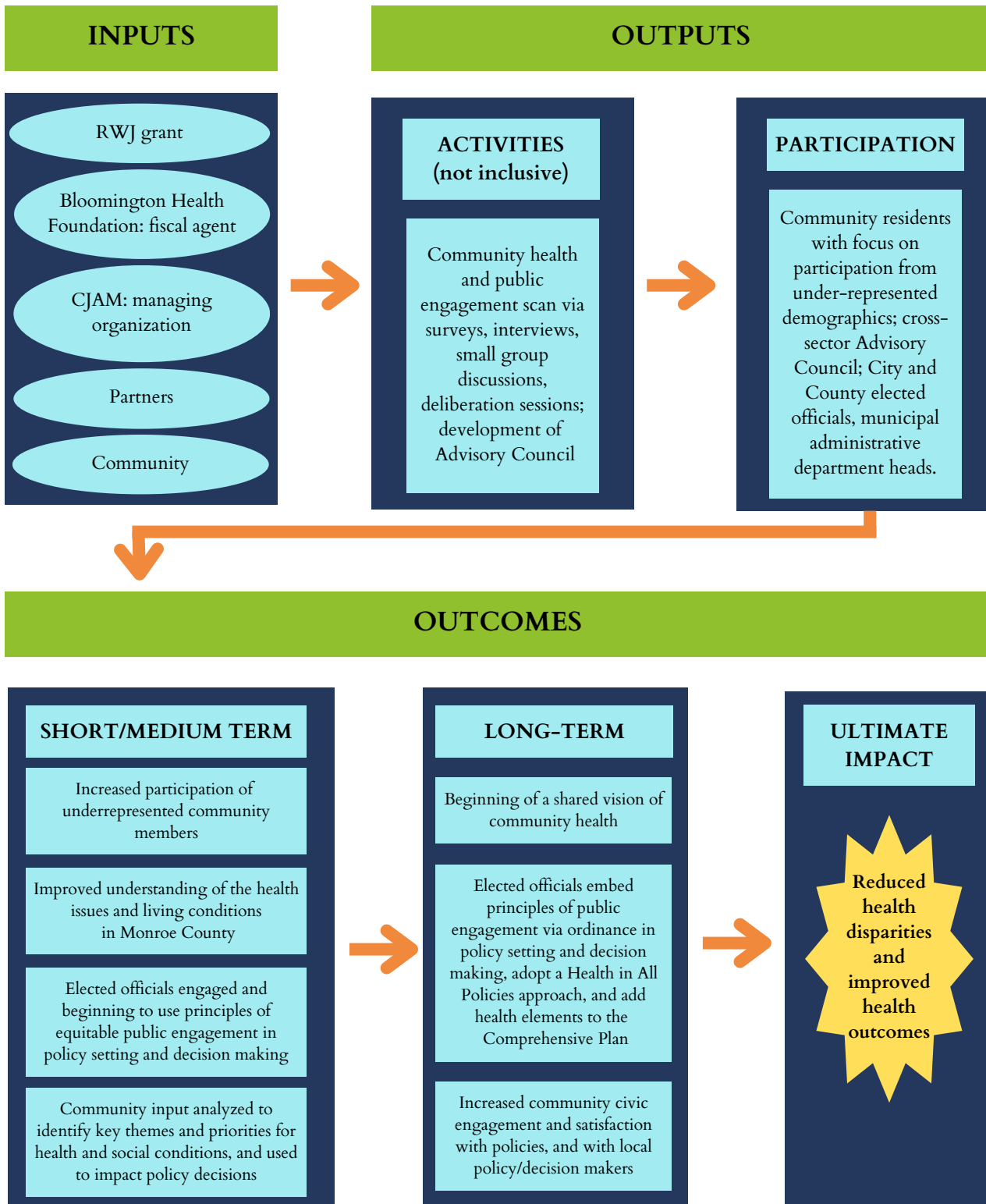
### Our Approach

There is a fundamental challenge in the way communities typically approach planning and decision-making. Historically, the people who are most impacted by policies are often left out of the conversation, are invited to participate but only in a superficial manner, or are brought into the conversation after decisions have already been made. If people do have the opportunity to be involved in the decision-making process, they are typically invited to provide their input in public meetings during a brief public comment period, typically allowing 3-5 minutes for each speaker. This type of involvement is not inclusive, deliberative, or sufficient to identify community needs or influence policy decisions. Thus, decisions and resource allocations are made without full understanding of the issues or impacts, which then leads to disparity and inequities. As such, the assumption underlying the Community Voices for Health project is that authentic, meaningful, and sustained public engagement that is embedded in local decision-

## CVH Toolkit: II: Introduction

making leads to a more informed public and to equity-based decisions. That then leads to a shared vision of community health that results in better health policies and systems, which ultimately lead to reduced health disparities and improved community health outcomes.

The logic model below is a representation of the implicit theory of change at the heart of the CVHMC initiative.



## Project Phases:

A scan of existing community resources and engagement practices



Facilitated information gathering from a broad base of community members



Solution-focused deliberative sessions between residents and government officials;



Collaboration on our local Community Health Improvement Plan (CHIP)



Planning for sustaining change beyond our initiative.

### Questions to spark further thought:

- What is the logic model or assumption underlying your initiative? Ultimately, what are you trying to achieve (long-term impact)?
- How will you define and apply an equity lens throughout your project?
- How broadly will you define “factors that impact health”? For instance, will you focus specifically on medical care, or will you include social determinants such as housing insecurity or economic stability?
- How will you define “decision makers”? Who is a part of that group?



## Section III: Getting Started

In this section:

- Gathering information on health and living conditions
- Identifying decision-makers
- Conducting initial interviews with community members
- Identifying and building relationships with underrepresented groups

### Getting Started

As we began our work on the CVHMC initiative, we recognized that the following information would be key:

Information on local health issues and living conditions

Names of organizations and individuals with responsibility for decision-making related to health

Names of organizations and community leaders with strong connections to underrepresented groups

Insights from personal interviews with a diverse pool of community members and leaders

We collected this information and used it to inform our planning of community discussions, guide our formation of a diverse advisory council, and help us develop inclusive outreach methods. It also helped us determine specific individuals and organizations from multiple sectors and demographics to reach out to, ensuring that we were as inclusive as possible.

To gain a solid understanding of health and living conditions within the community, we looked at a variety of data for Monroe County, Indiana and compared those local conditions to those of the state of Indiana and the nation. A full list of data our team reviewed, including example data sources, can be found in [Section III Appendix A](#). Most information is available from national databases, such as the U.S. Census Bureau, Annie E. Casey Foundation Kids Count Data Book, or the Robert Wood Johnson Foundation's County Health Rankings. Some data was more specific to our state and local area. A sample summary of social and health issues can be found in [Section III Appendix E](#).

Multiple individuals and organizations in a community typically share responsibility for decision-making related to health. Our team identified those with responsibility for such decision-making and their existing channels for engaging residents. This information was useful in identifying ways to meet community members in places and at events where they planned to be already. In addition, by knowing who the local decision-makers were related to health issues, we were better able to focus our communication efforts on the people who could make an immediate difference, as well as to recruit decision-makers to participate in the project.

Some of the decision-makers we identified as influential in health decisions in the community were:

- Elected government officials (including Township Trustees)
- Staff in government departments
- Hospitals
- Medical clinics and service providers
- Social service agencies
- Neighborhood associations

For each organization, we identified a point of contact, ideas for engaging that organization in our process, and existing ways the organization currently reaches out to community members (e.g., government newsletter, neighborhood association email list, town council meeting). We used this information to guide all aspects of project implementation. See [Section III Appendix B](#) for a sample worksheet.

To make sure our public engagement efforts brought a broad range of voices to the table, we found it helpful to identify and involve in any way we could individuals with strong connections to underrepresented groups. Thinking mindfully about these connections was crucial and helped us develop an effective outreach plan. Guidance on effective public engagement can be found in [Section III Appendix F](#).

“In general we tend to sit back and accept things as they are; we get comfortable and we don't think about the people out there that don't have the food or the housing and don't have the basics to make their life a happy one.”

*Response from Stage 1 Interview*

“The voices we don't hear from in even the most open of processes are people who are too busy with day-to-day life, people who would be intimidated by coming to a public meeting, [or] going before [a] government body.”

*Response from early stage interview*

Our team identified numerous groups that are typically underrepresented in health decision-making processes, and individuals with strong connections to those groups to serve as liaisons. You will find a sample worksheet for this in [Section III Appendix C](#). Examples of these groups include:

- Individuals with disabilities
- Black residents
- Rural residents
- College students and young adults
- Older adults
- Asian residents
- LGBTQI+ population
- Individuals experiencing domestic violence
- Refugees and immigrants
- Veterans of military service
- Individuals and families experiencing homelessness
- Low-income individuals and underinsured/uninsured residents
- Individuals with substance use issues
- Individuals living with mental health issues
- Individuals recently incarcerated

### OUR PROCESS IN BRIEF: Engaging community organizations

Identify a point of contact for each organization

Generate ideas for engaging organizations

Identify engagement practices within organizations

Identify new engagement practices and leverage existing ones

As the final component of this foundational information-gathering phase, we conducted nearly 50 interviews with community members identified as key informants. We had numerous goals for these early interviews, including to:

- Learn more about the interviewees' professional and personal experiences
- Build relationships
- Share the proposed goals and processes of the CVHMC project
- Gather advice for a successful project, including recommended questions, contacts, and outreach methods
- Learn about upcoming decisions regarding health that might benefit from insights from this project
- Identify individuals interested in being involved in the initiative, especially those who identify as a member of or are connected with an underrepresented community

Sample interview questions can be found in [Section III Appendix D](#).

### Questions to spark further thought:

- Is there a recent community health needs assessment from which to draw information about community health issues?
- What data sources will you use to understand local conditions and the social determinants of health that affect local health outcomes?
- Who are the key individuals and/or organizations with responsibility for decision-making related to health in your community? Who is involved in public engagement practices?
- What community members and organizations are closely affiliated with underrepresented populations in your community?
- What community resources already exist to help launch or support your effort?
- What local resources, groups, or people are involved in public engagement efforts?

## Section III Appendices Links

Appendix A: Health and Living Concerns Sample Data Sources

<https://tinyurl.com/Sec3AppendA>

Appendix B: Health Decision-Makers Worksheet

<https://tinyurl.com/Sec3AppendB>

Appendix C: Connecting with Underrepresented Communities Worksheet

<https://tinyurl.com/Sec3AppendC>

Appendix D: Sample Questions for Early-Stage Interviews

<https://tinyurl.com/Sec3AppendD>

Appendix E: Sample Summary of Social and Health Issues

<https://tinyurl.com/Sec3AppendE>

Appendix F: Guidance on Effective Public Engagement

<https://tinyurl.com/Sec3AppendF>

Please use the following QR code to view these resources on our website:





## Section IV: Outreach, Engagement, and Communications

In this section:

- Goals of marketing and outreach
- Planning and organizing points of contact
- Creating a master contact database
- Working with the press

A key intention of this initiative was to elevate the voices of those who are not usually heard. As one might expect, this is a challenging undertaking. People who are marginalized and historically excluded are often not eager to participate, and especially to share personal information about their health and their life circumstances. Many have experienced violations of trust in the past and it is hard to reestablish trust in a new environment with unfamiliar people. Add to that the challenges of doing so during a pandemic, and it sometimes felt like an insurmountable problem.

Our team worked together to identify as many people and organizations as we could that might serve as conduits to community members, especially in underrepresented groups. We developed a written Marketing and Outreach Plan that remained fluid, and we expanded or modified it when we identified opportunities (See [Section IV Appendix A](#)). Our team included 1.5 FTE communications and outreach employees who then implemented the plan.

### Our Marketing and Outreach Plan comprised four key goals:

Increasing  
community  
awareness  
about the  
project

Strengthening  
existing  
relationships

Creating and  
nurturing  
new  
relationships

Encouraging  
participation  
in our  
community  
conversations

We identified the marketing and outreach strategies that we could use to fulfill these goals. The points of contact that we selected were:



The first step in the plan was to build an online database of the contacts as we identified them. We expanded the database throughout the project as we established relationships with different community groups, individuals, and cross-sector partner organizations.

Within the master contact list, we created categories relevant to the project so that we could also send targeted communications. Those categories included: businesses, City and County boards and commissions, elected officials, faith leaders, health and medical providers, media contacts, neighborhood associations, non-government leaders, and social services. In addition to contacts within these categories, our master contact list included cultural centers, university departments, and other local nonprofits.

One key means of information dissemination was the email marketing platform Constant Contact. Since this platform provides an option for recipients to unsubscribe from the emails, we were able ethically to use contact information from websites and other publicly available sources. For each outreach opportunity, we adhered to our Marketing and Outreach Plan to maximize our audience reach. See [Section IV Appendix B](#) for the full outline of the plan.

### A word on working with the press

Ours is a moderately-sized community, with one primary newspaper, a university newspaper, a few independent print publications, a local magazine, and several local news blogs. The diversity of these media opportunities was both a blessing and a curse. Each operates in its own way, has its own guidelines for stories, and has its own way of engaging with the public.

Developing relationships with the editors and writers of publications in the community is vital if those relationships don't already exist. Cultivating such relationships and garnering respect and trust takes some time and effort, so should be started early. Following are examples of ways to do this:

- Call key contacts on the telephone to introduce yourself and your project. Ask about their editorial guidelines. If you're talking to an editor, ask if there is a particular reporter who is assigned to this kind of story.
- Occasionally send concise and clear materials from your project by email. Send only one or two documents at a time, but keep yourself in front of the editors/writers by taking advantage of opportunities to update them (flyers, newsletters, announcements, etc.)
- Send emails with advance notice of events that are coming up, letting him/her know that a press release is coming.
- If you're hoping for a story, ask yourself: "Is this news?" News is something that is significant and affects a large number of people. Events, public policy changes, activities that involve prominent local figures, etc. are examples of newsworthy topics.

A particular issue we struggled with was reconciling confidentiality for our participants with obtaining media coverage, particularly in relation to our Small Group Discussions (see Section VI.) One of our primary objectives, of course, was to educate the community regarding the health equity issues we were working to address, so clearly publicity via the media was key. However, sometimes community members shared personal stories that involved heartache. This was particularly true during the information-gathering phase. We wrangled for some time with the question of how to balance the importance of media coverage with the importance of creating a safe environment for participants to share intimate information. We did not arrive at a unanimous viewpoint on this, but ultimately decided that providing a safe and confidential space for the participants was most important.

See Section IV Appendix C-F for examples of print media pieces, flyers, newsletters, and press releases.

## Questions to spark further thought:

- How will you use best practices for outreach, marketing, and communications to reach as many community members as possible, especially those from underrepresented groups?
- Have you thought about the demographic make-up of your community and planned ways to appeal to different groups? (For instance, Instagram likely won't work well for older adults in the community.)
- Which audiences in your community will be the most challenging to reach and/or engage with? How do other community organizations generally reach out to these audiences?
- Which keywords and catchphrases best capture the essence of the project, and how can these be used in marketing materials in order to generate interest in the project?
- How can participation be encouraged through incentives (gift cards, for example)? How can elimination of barriers to participation best be illustrated by marketing and communications efforts and materials?
- Are there existing contact databases in the community that can be leveraged in order to reach bigger audiences? Will it be more effective and efficient to "cast a wide net" or to focus efforts on specific groups for participation?
- Are you familiar with all print, radio, television, and non-traditional media outlets in your community? Do you know the editor(s) of your local print publication(s)? Key reporters? Important social media influencers?
- How will you handle balancing the creation of a safe space for information sharing vs. openness about your work, and taking advantage of the media to help educate the community about your efforts?

## Section IV Appendices Links

Appendix A: CVHMC Final Communications Plan

<https://tinyurl.com/Sec4AppendA>

Appendix B: CVHMC Detailed Communications Action Plan

<https://tinyurl.com/Sec4AppendB>

Appendix C: Sample Press Release

<https://tinyurl.com/Sec4AppendC>

Appendix D: Sample News Articles

<https://tinyurl.com/Sec4AppendD>

Appendix E: Sample Outreach Emails

<https://tinyurl.com/Sec4AppendE>

Appendix F: Sample Flyers

<https://tinyurl.com/Sec4AppendF>

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## Section V: Establishing an Equitable Organizational Structure

In this section:

- Creating internal structure for a project team
- Ensuring representative membership
- Roles and components within organizational structure
- Challenges and learnings during this process

Establishing an equitable internal organizational structure was a significant and foundational priority for this project. To maintain an outward lens centered on equity, it was critical for us to look honestly at our own actions. We asked questions at each step to gauge whether there was diverse representation in the project's core organizational structure as well as in our external work. In creating the structure and in recruiting for project activities, we focused our efforts on maintaining that equity lens, always evaluating the diversity of the representation, the gaps in the representation, and the efforts needed to fill those gaps for true representation.

While the community resource and engagement scan was being performed (see Section III), we also developed the internal structure of our project team. There were many people involved in carrying out our initiative, including Community Justice and Mediation Center (CJAM) staff (the umbrella organization and grantee), private consultants, university faculty, a fiscal sponsorship agency, national advisors, community members, research assistants, and others with relevant expertise. We determined the functions needed and devised a structure that would be as clear and practical as possible. (As people come and go, it is prudent to track all members and participants over time, to save having to re-create the list later.)

Initially, we outlined the following elements of our structure:

**A Steering Committee – to provide guidance and direction to those doing the on-the-ground work**

**An Advisory Council – to provide representative counsel, meaningful participation in the ongoing work, and links to important stakeholder groups**

**An Implementation Team – to discuss details and carry out the day-to-day work of the project (staff and consultants)**

We considered the specific roles that we would incorporate into each of the first two of these groups (the Steering Committee and the Advisory Council), the characteristics and expertise we should seek in the members of each, and the functions that we would assign to each. It was important to assess the perspectives represented to ensure that the membership reflected the community demographics as closely as possible. We then wrote descriptions for these two groups and our outreach began. (See [Section V Appendix A](#) and [B](#).) We allowed for flexibility so that, over time, we could make small adjustments to the membership, structure, and activities of these groups, based on our learnings and progression in the stages of our work plan. We maintained this iterative process in creating the groups and the tasks so that there could be openness in adapting to community needs.

In addition, we created subcommittees when we deemed those to be helpful adjuncts. For example, the Steering Committee added a Sustainability and Infrastructure subcommittee to develop a plan that would support long-term, inclusive, and effective decision-making even after the grant-funded initiative concluded. The Advisory Council (AC) added two subcommittees which we called Action Teams -- one short-term, and one longer running: the Deliberative Engagement Action Team, and the Leadership Engagement Action Team (LEAT).

*It was important to assess the perspectives represented to ensure that the membership reflected the community demographics as closely as possible.*

The Deliberative Engagement Action Team met only a few times and was instrumental in providing feedback that informed the design of our deliberative engagement sessions with community members and government officials (see Section VII). The latter group, LEAT, continued to meet monthly throughout the remainder of the initiative, providing leadership within the AC to help develop and direct its purpose and scope of work. As the grant neared its end, we drew on LEAT members to assemble a small Transition Planning Work Group. This group was instrumental in helping to determine the role and function the AC would take after the conclusion of the grant, so that the health equity and public engagement efforts would continue.

Both the Steering Committee and Implementation Team were internal groups made up of those members doing the work of carrying out the initiative. By contrast, the Advisory Council was a group made up of external community members. This group, therefore, was managed and functioned differently from the others, and warrants some additional explanation.

The Advisory Council, which varied in size over time between 25 and 40 members, had two primary roles. Its functions were:

- To collaborate with the team, and to provide guidance, oversight and active involvement in project design and implementation; and
- To provide connections to underrepresented groups in our community through already established trusting relationships

A member of the Implementation Team served as liaison to the Advisory Council, and was responsible for all communications, recordkeeping, relationship-building, and convening of meetings. As with any volunteer group, it was important to maintain friendly, enthusiastic, and regular communication to help hold their interest and show that they were valued. The AC included self-identified members of underrepresented communities, non-specific community members, health care providers, social service providers, activists, those with specific expertise, and representatives from all four of our community's elected decision-making bodies. See sample AC agenda ([Section V Appendix C](#)) and presentation slides from the meeting ([Section V Appendix D](#).)

Having government representatives involved in the project from the start was significant. This was vital to our efforts to bring about change in the community. The work we were doing, and the change we hoped to bring about, focused on bringing equitable and inclusive public engagement to government policy and decision-making. Having government officials directly involved – participating in the meetings, gaining facilitation skills, learning how to integrate health in policymaking -- helped them to have a solid understanding of the sometimes difficult-to-grasp efforts we were making, and for some, spurred a particularly strong commitment to the end goal of equitable, participatory governance. More information on this topic can be found in Section VII and VIII.

Overall, our level of diversity could be described as moderate. Despite our diligence, we did not achieve the breadth of diversity we had hoped for. This was a significant point of learning for us and reinforced just how critical it is to begin developing trust and strong relationships with marginalized groups at the very outset.

*It was important to maintain friendly, enthusiastic, and regular communication to help hold their interest and show that they were valued.*

## Challenges and Learnings

One of the most difficult aspects of the project overall has been achieving the level of diversity and inclusion we intended. In the simplest terms, here are some of our key learnings:

The diversity effort needs to begin immediately. The most fundamental aspect of bringing diverse representation into the work is trust. Trust does not come easily or quickly. It must be earned, and that requires integrity, reliability, steadfast effort, and time.

Vigilance is necessary. The priorities of diversity and equity must always be at the forefront of every aspect of the work.

Demonstrating to prospects the ways in which joining will be meaningful to them is key to generating interest.

Allies who already have the trust of groups you want to reach are critical conduits.

It is also important to keep in mind that the diversity you achieve is not static. Advisors and helpers will rotate out almost as quickly as they come in. The outreach effort should remain strong and never-ending. Another learning for us was that it would likely be helpful to develop some form of exit interview to spark reflection and solicit feedback from those who are departing. This could provide vital information to inform future efforts and possibly improve retention. A copy of the final Advisory Council Survey can be found in [Section V Appendix E](#).

### PROCESS IN BRIEF: Establishing equitable organizational structure

Determine needed functions and devise a clear and practical internal structure

Write descriptions for each group and subcommittees; identify meeting frequency and group sizes

Recruit participants by conducting outreach to community members and government officials

Continue outreach efforts throughout project; conduct exit interviews for departing members

### Questions to spark further thought:

- How will you organize the leadership and internal structure of your project? Is there an umbrella organization that will oversee or provide a home base for the effort?
- What health organizations and individuals, including those connected to social issues that impact health, should be represented in the leadership of the project?
- Who needs to be a part of your organizational structure to ensure equity and diversity?



## Section V Appendices Links

Appendix A: CVH Steering Committee Description

<https://tinyurl.com/Sec5AppendA>

Appendix B: CVH Advisory Council Description

<https://tinyurl.com/Sec5AppendB>

Appendix C: Sample Advisory Council Meeting Agenda

<https://tinyurl.com/Sec5AppendC>

Appendix D: Sample Advisory Council Meeting Slides

<https://tinyurl.com/Sec5AppendD>

Appendix E: Final Advisory Council Survey

<https://tinyurl.com/Sec5AppendE>

Please use the following QR code to view these resources on our website:



### Section VI: Identifying Community Health Topics and Concerns

In this section:

- Using various methods to gather information on health and health-related concerns, issues and interests
- Collecting, analyzing and sharing evaluation data
- Providing facilitation training for community volunteers

Once we learned about the existing resources and public engagement practices in the community and established our operational structure (see Sections III and V), it was time to roll up our sleeves and get to work. Our first step was to gather information from as many community members as possible, with a particular eye toward those who are often underrepresented when those in power make policy decisions. As was mentioned in the Introduction, we included social determinants of health in our definition of health and health impacts. Social determinants of health include such concerns as food and housing security, community safety and support systems, employment/economic stability, education, neighborhoods and physical environment (i.e., parks, playgrounds, transportation), systemic racism, and so on.

Our goal to reach as many people as we could never wavered, and to the extent possible during a pandemic, we made every effort to “meet people where they were.” (See sample tools in [Section VI Appendix A](#).) Gathering this baseline information from community members and key decision-makers across sectors was a fundamental part of our project. This information allowed us to grasp a deeper and more complete understanding of health issues in our community. Moreover, we used the information gathered as a basis for public deliberation and other aspects of the project. Since we were largely unable to have in-person contact, we developed a variety of alternative methods of communication to appeal to a variety of people. Our methods were:

- Structured, professionally facilitated small group discussions held via Zoom as well as in-person in varying locations
- One-on-one conversations conducted by phone or Zoom
- A “Share Your Story” form for written submissions (see [Section VI Appendix B](#) and [C](#))
- A youth art contest called, “Images of Health” (see [Section VI Appendix D](#))

During the small group discussions, we wanted to make sure participants had a chance to share their personal stories related to health and discuss health issues of greatest concern to them. With this goal in mind, our team framed questions very broadly to make sure we weren't leading the responses of participants. The two primary questions we posed were:

- **Health depends on many things. What's important to you?**
- **What do you want community leaders and decision-makers to know about what's important to you?**

We also developed standardized processes for communicating with participants, facilitating discussions, taking unattributed notes, and disseminating surveys to ensure participants in different sessions had consistent experiences. And of utmost importance was that the small group discussions began with a review of “group agreements” that included the importance of confidentiality.

Between November 2020 and June 2021, our team hosted 19 small group discussions and a handful of one-on-one conversations. We led 17 of these small group discussions in English, and two in Spanish. Due to the COVID-19 pandemic, we held all but one discussion through Zoom. A session with developmentally disabled adults was held in person to eliminate the barriers of technology.

Individual conversations and the “Share Your Story” form allowed us to offer more private formats for sharing information, including remaining completely anonymous. Both methods consisted of uniform prepared questions. (See [Section VI Appendices B](#) and [C](#))

We also hosted a “PhotoVoice” art contest for middle school and high school students. While this was a part of our information-gathering, it didn't take place until later in the project (see [Section VI Appendix D](#) for more information).

### **Facilitation Training for Small Group Discussions**

To extend community buy-in and awareness of our initiative, we worked to recruit and train community members as facilitators and notetakers to assist with our small group discussions. In November 2020, we led a facilitation/notetaking training designed specifically for the small group discussions. Our trainers started the session by modeling, through a short role-play, what the small group discussion process was like. They then walked participants through the project objectives, reviewed group agreements and sample questions to guide the discussions, shared templates for notetaking, and discussed the outline and surveys used by facilitators. All trainees were required to sign a confidentiality agreement.

After receiving this guidance, trainees had an opportunity to practice their facilitation and notetaking skills by role-playing a mock small group discussion led by experienced facilitators.

At the end of that practice session, trainees reflected on the training and discussed improvements that would best support them and the process. Finally, we hosted two additional practice sessions, during which trainees had further opportunities to ask questions and practice their facilitation skills.

Our Facilitation Training Guide can be found in [Section VI Appendix E](#).

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### Holding the Small Group Discussions

A significant component of drawing a diverse and inclusive group to participate in the small group discussions was identifying and removing barriers to participation. Some of the ways we did that were:

- Maintaining communication with participants, facilitators and notetakers to prepare them for a productive conversation
- Providing services such as translators, transportation or childcare stipends.
- For in-person sessions, creating a welcoming space and providing snacks and water.

In addition, to demonstrate to participants that their time and the expertise they shared from their lived experience was valuable, we offered small stipends in the form of gift cards.

Whether in-person or online, maintaining a friendly, welcoming space was a significant part of hosting the conversations so participants could be both vulnerable and trusting with each other, knowing that the skillfulness of the facilitators would support the conversation.

“I appreciated the personal stories and perspectives people shared. These were powerful and helped to highlight various themes. I also appreciated the various professional perspectives people brought to health issues, as everyone seemed to have something valuable to share based on their work, education, and experience.”

*Small Group Discussion Feedback*

## Evaluation, data analysis, and theming

In all aspects of this information-gathering phase, it was critical to record everything we learned, while carefully protecting the integrity of the data and the confidentiality of the participants. The data team created a spreadsheet tool to review and summarize comments made during the small group discussions. We sent summaries of the session notes to the participants to review for accuracy and carefully reviewed them ourselves to ensure accuracy and protection of privacy. Any direct quotes from meetings used in data summaries were cited anonymously.

We also created two surveys for the small group discussions – a pre-session demographic survey to help us track the diversity of participants, and a post-session evaluation survey that helped us make continuous improvements to our small group discussion processes. Samples of those surveys in both Spanish and English may be found in [Section VI Appendix F](#).

Using the spreadsheet mentioned above and a process we developed for theming and coding, we grouped the feedback from the one-on-one conversations, the Share Your Story forms, and small group discussions into three main health issues. Detailed preliminary summaries were compiled shortly after the small group discussions concluded in June 2021. Later, we created more condensed summaries to share more extensively (see [Section VI Appendix G](#) for a sample.)

Both versions of the data summaries were shared with participants and checked carefully to make sure key issues raised by community members were not inadvertently omitted. This was an important step in building trust and demonstrating that we valued their voice and experiences. This coded data was then used to frame the issues for the community deliberation sessions described in the next section.

### PROCESS IN BRIEF: Identifying community health topics and concerns

Develop discussion questions, group agreements, and standardized communication processes

Train facilitators and notetakers; conduct practice sessions

Conduct marketing and outreach and identify conduits to marginalized community members

Host small group discussions and one-on-one conversations; evaluate and share the data

“I liked the opportunity to talk about concerns in small groups. It was good to hear people listen to each other about their concerns about health care and I was impressed by how much our concerns overlapped and we were able to find commonality.”

*Small Group Discussion feedback from Advisory Council member*

## Questions to spark further thought:

- What are the methods you will use to identify the health concerns of community members? One-on-one conversations? Small group discussions? Written stories? Other?
- How will you ensure that you hear from people and communities that are typically underrepresented? Who will lead those outreach efforts? Do you have an Outreach Plan?
- Who can reach out to communities where English is not the primary language?
- What public spaces are available that would be most easily accessible for marginalized populations? What days/times might work well for various groups?
- How will you encourage participation by eliminating barriers (e.g., providing transportation, childcare, and so on)?
- What can you do to create a welcoming and safe environment?
- How will you capture the information shared by participants? Who will collect the data and summarize the key themes that emerge? How will you protect confidentiality?

## Section VI Appendices Links

Appendix A: Sample Engagement Tools

<https://tinyurl.com/Section6AppendA>

Appendix B: Share Your Story Forms

<https://tinyurl.com/Sec6AppendB>

Appendix C: Share Your Story Flyers

<https://tinyurl.com/Sec6AppendC>

Appendix D: Images of Health Flyer and Form

<https://tinyurl.com/Sec6AppendD>

Appendix E: Small Group Discussion Facilitator Training Guide

<https://tinyurl.com/Sec6AppendE>

Appendix F: Small Group Discussion Surveys

<https://tinyurl.com/Sec6AppendF>

Appendix G: Small Group Discussion Participant Summary

<https://tinyurl.com/Sec6AppendG>

Please use the following QR code to view these resources on our website:





## Section VII: Framing the Issues and Conducting Deliberative Discussions

In this section:

- Defining and outlining deliberation
- Foundational principles for conducting deliberation
- Training facilitators and notetakers
- Outreach and engagement for deliberative discussions

An integral part of the process of making decisions to address public issues is deliberation. In our context, we defined deliberation as a method of carefully considering different approaches to address an issue and what might be needed to move toward solutions. Our next phase, after the private conversations and small group discussions, involved solution-focused deliberative discussions.

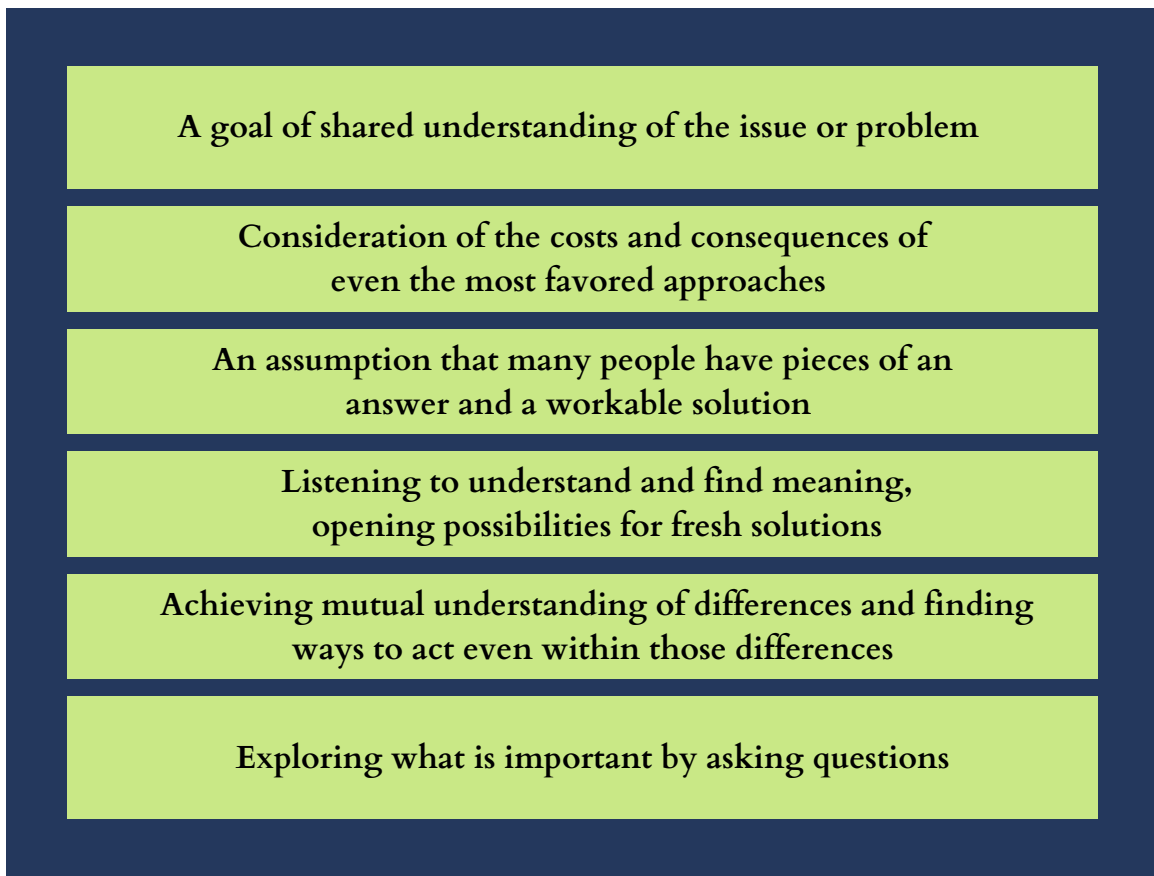
The deliberation sessions used a model inspired by the democratic deliberation work done by the Kettering Foundation, Public Agenda, and other groups. The jumping off point for these deliberative sessions was the set of concerns compiled from the community conversations and small group discussions. To prepare, we considered key issues that had been identified, and highlighted what was needed and what might have to be given up in order to move toward solutions. We then summarized this information and whittled it down to a one-page “deliberation guide” for participants to review in preparation for deliberative discussion.

Since deliberation is a word used in common language, it was important to ensure that participants understood that in our context it meant something very specific. Therefore, in our outreach efforts, and at the beginning of each deliberative discussion, we sought to educate participants about what we meant by “deliberation.” We created two handouts in both English and Spanish (found in [Section VII Appendices A](#) and [B](#)):

- An update to explain the overarching goals of the project, the phases of the initiative thus far, and where we were headed. This handout included an infographic outlining the deliberation process
- The deliberation guide mentioned above which was intended to clarify the topics, to spark ideas and to get the conversation started.

We hoped that the composition of the deliberative discussion groups would be a mix of community members from all walks of life as well as elected government decision-makers. Although diversity of participants was a priority, we also recognized that sometimes participants felt more comfortable sharing personal information if they were within a more homogenous group. Therefore, we offered opportunities specifically for groups of Spanish speakers and those who identify as Black/African American – two primary racial/cultural groups in our community. Following are some foundational principles we set out for the deliberative sessions:

### Foundational Principles for Deliberation



Between August 2021 and February 2022, our team hosted 10 deliberative sessions during which we brought together nearly 100 community members, including elected officials. Community members included diverse representation from a variety of demographic groups. Six of the sessions were held via Zoom, and four sessions were held in person in locations near our intended participants.

We paid careful attention to the details of the deliberative discussions -- the facilities and set-up of the room for in-person sessions, the technological details for virtual sessions, and the approach for both types. As we did with the small group discussions, we applied an equity lens, meaning that we checked in with participants to ensure that transportation, childcare, and other needs were not barriers to being a part of the conversation.

These deliberation sessions were distinctly different from the small group discussions mentioned in the previous section. The small group discussions were exactly that – discussions of health-related issues and concerns in small groups. While those discussions were facilitated, their intent was simply to gather information. In contrast, the deliberation sessions were comprised of both community members and elected officials. They were designed to provide an open and trusting atmosphere in which to respectfully deliberate about key issues, with an eye toward solutions.

### Facilitation Training for Deliberation

In addition to the training for the facilitation of the small group discussions, our team led a facilitation training designed specifically for the upcoming deliberative sessions.

During the training session, we focused on the following content areas:

- Discussion of deliberation and its goals
- Role differences for facilitators and notetakers
- How to facilitate productive conversations about difficult topics
- Framing questions in neutral and open-ended ways to lead to a truly unbiased and deliberative process
- Creating a safe space where participants could discuss health issues in honest, upfront, and clear ways

Notetakers were provided with templates for notetaking and received training on how to best capture content authentically and share it with the group.

After receiving this guidance from team members, trainees had an opportunity to practice their facilitation and notetaking skills. At the end of the practice session, they reflected on the process and made recommendations for improvements. We then held a second session the following week to provide further practice. Once again, trainees were asked to sign a confidentiality agreement confirming their pledge not to attribute any comments made during discussions to specific individuals. See Section [VII Appendix C](#) for the training materials and the questions that facilitators used to guide the process.

Advisory Council members participated in the deliberation sessions themselves, serving as facilitators, notetakers, and participants. They also helped to recruit other participants. Since the members of the Council represented key constituencies that are often marginalized, it was important to draw upon this group to invite others to participate.

Bringing community members together to talk about important issues creates opportunities for them to exercise and build “civic muscle.” Civic muscle refers to many things. For the purposes of our project, we saw it as the strength needed to mobilize people and resources for change while also fostering community resilience and stability. We aimed to create a community that would stay fit and use its civic muscle to sustain equitable, inclusive, and participatory decision making on health-related matters.

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### Outreach and Engagement

Our outreach strategies for the deliberative sessions were, in large part, the same as were described in Section 4, but with one notable difference. For these deliberation sessions, we needed to engage both community members and elected officials. Bringing in elected officials required a different kind of outreach.

We are a moderately sized community with a county-wide population of approximately 147,000 residents. This makes our elected government officials more accessible than they might be in larger communities. We took a direct, personal approach to inviting our government leaders to participate: we simply asked them to. This approach was quite successful. With only one exception, we had at least one elected official at each deliberative session, and at times as many as three. Making one-on-one contact also afforded us the opportunity to provide more information about our initiative and help government leaders more fully understand our objectives.

“There was a mutual feeling of respect. I think that people were really listening to each other and that enabled the conversation to build in a productive way.”

*Response from deliberation session survey*

## Evaluation and Analysis

Again, as we had done with the small group discussions, we used the two types of surveys we had developed – a demographic survey and an evaluation survey. (See [Section VII Appendix D](#).) Also as before, we created a spreadsheet tool to review and summarize comments made during the deliberative sessions. Detailed summaries of the deliberation were created immediately following the sessions and sent to participants to review for accuracy. Subsequently, we themed and coded the content and created more condensed summaries that were suitable for sharing. Each version of the data summaries was checked carefully to make sure key issues raised by community members were not inadvertently omitted. (See [Section VII Appendix E](#) for a sample data summary.)

### A selection of quotes from deliberation session surveys:

“I suspected I would hear great stories and experiences, but I was really shocked at how vivid the examples became as we worked through them. It was a reminder that it is always good to hear those kinds of real examples.”

*Response from deliberation survey*

“We all wanted to collaborate into a bigger picture to understand what Bloomington is struggling to provide for health services in general.”

*Response from deliberation survey*

“Since we are all having problems with access, it would be nice to have a central navigation point. It would be cool to have a general case management agency or city position where someone can go and state a problem and get someone to help them.”

*Response from deliberation survey*

## Questions to spark further thought:

### Conducting Deliberation Sessions

- Who will lead outreach efforts to encourage marginalized people to participate? Do you have an Outreach Plan?
- How will you ensure that elected officials participate and engage with the public in these deliberative sessions?
- What public spaces are available that would be most easily accessible for various populations? What days/times might work well for various groups?
- How will you eliminate barriers (e.g., providing transportation, childcare, and so on)?
- What can you do to create a welcoming environment?
- Do you have facilitators who understand deliberation in this context and are able to lead sometimes difficult discussions in constructive and supportive ways?
- What data will be important to collect from these discussions? Who will collect the data and summarize the key themes that emerge?
- What support do you need that you do not currently have to conduct these sessions effectively?

### Facilitation Training

- With a diversity and equity focus in mind, how will you recruit people to become facilitators and notetakers, including those who can speak the languages found in your community?
- Who has expertise in the kind of deliberation to be used and can lead the development and planning of the sessions?
- Who can develop the training guides for both facilitators and notetakers?
- Who can lead facilitation and notetaking training?

## Section VII Appendices Links

Appendix A: CVHMC Deliberation Overview

<https://tinyurl.com/Sec7AppendA>

Appendix B: CVHMC Deliberation Guide

<https://tinyurl.com/Sec7AppendB>

Appendix C: Deliberation Facilitation Training Guide

<https://tinyurl.com/Sec7AppendC>

Appendix D: Deliberation Surveys

<https://tinyurl.com/Sec7AppendD>

Appendix E: Deliberation Session Summary

<https://tinyurl.com/Sec7AppendE>

Please use the following QR code to view these resources on our website:





## Section VIII: Working with Elected Governing Bodies

In this section:

- Goals for working with elected officials
- Conducting a governmental "engagement scan"
- Updating government officials on project processes
- Challenges of working with elected officials
- Best practices for keeping elected officials engaged throughout the project

The goal of the CVHMC initiative was to design and test a framework that provides opportunities for effective, equitable, and inclusive public engagement in decision-making that impacts community health. At the heart of this is building strong relationships with elected members of city and county governing bodies.

In any community there are many decision-makers, including and certainly not limited to policy makers, funders, and those making health programming and service decisions. Given our limited time and capacity, we focused our efforts on trying to strengthen the culture within which city and county officials make decisions that impact health. Specifically, we hoped that elected officials would adopt an equitable community engagement process in which they would intentionally reach out to marginalized and underserved communities, particularly in relation to policies that affect community health and well-being. (For clarity, when we refer to elected officials or government leaders, we mean elected members of governing bodies; not elected department heads, clerks or other staff members.)

More specifically, we believe that when elected officials make decisions after hearing the voices of people most affected by the proposed policy, they will make better policies. Better policies, then, lead to reduced health disparities and improved community health outcomes.

"I welcome more conversations about how to leverage our legislative abilities and local resources to make our county healthier and happier. Better coordination among service providers is a good goal for ongoing discussion."

*Meeting reflection by government official*

To gather background information, team members met with several city and county officials and department heads. During these conversations we learned about such areas as:

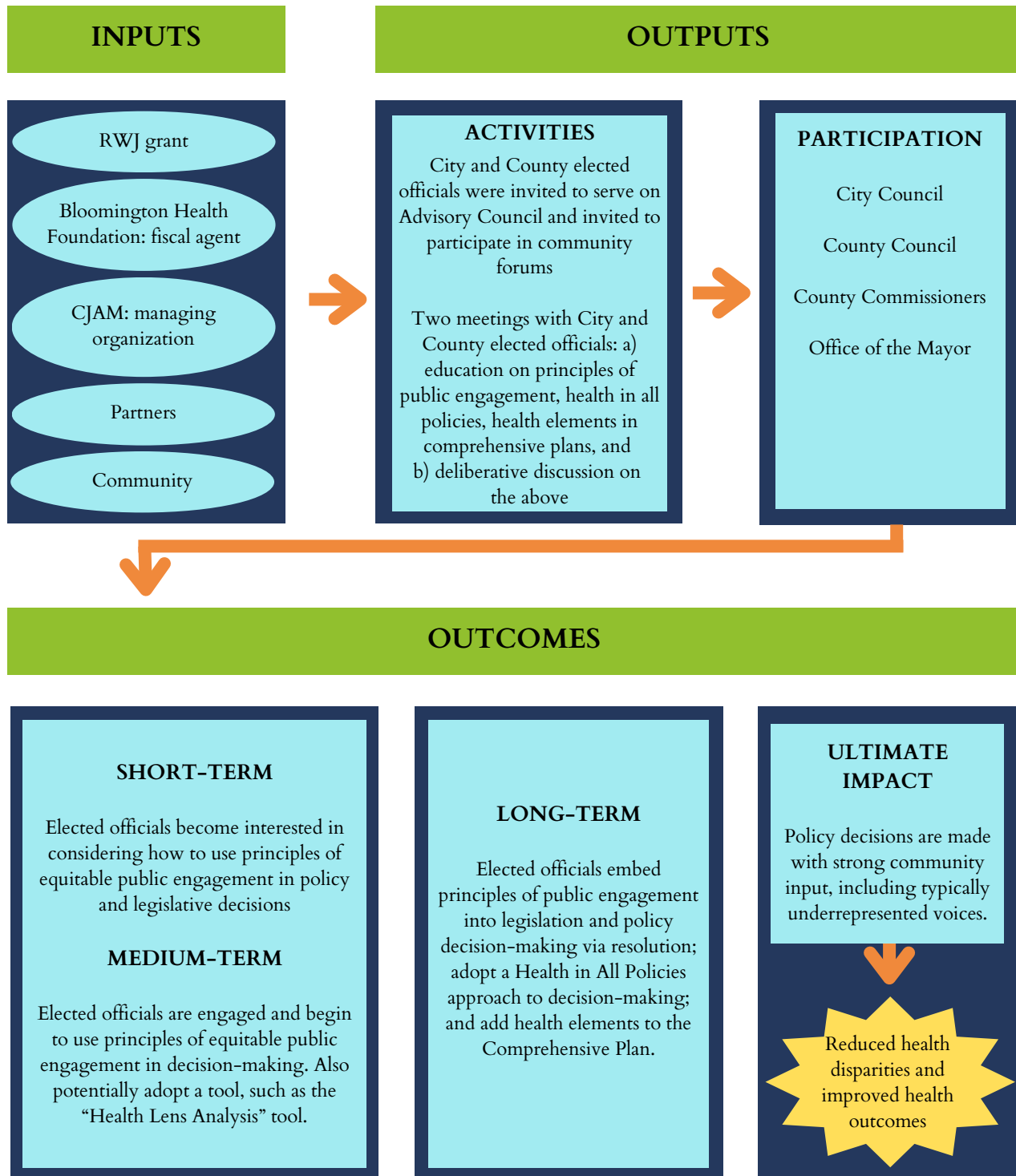
- Departmental roles and responsibilities
- How departments includes public voice in their work
- How a particular decision-making body identifies the needs in the community
- Lessons learned
- What they would like to see changed about their decision-making process

After this governmental “engagement scan,” (see [Section VIII Appendix A](#)) we invited members of the City and County Councils, County Board of Commissioners, and Mayor’s office to participate on the CVHMC Advisory Council. As a result, two members of the City Council, two members of the County Council, and one of the County Commissioners agreed to join. This participation is essential in educating elected officials about the project and helping them understand how their work is inherently related to community health. Periodically, CVHMC team members met with the elected officials from the Advisory Council to continue to strengthen those relationships and to receive ongoing feedback from their particular perspectives.

To further engage and educate elected officials, we designed and conducted two sessions specifically for them, related to elements of equitable policy and decision-making. These included all members of our governing bodies, not just the few on our Advisory Council. (Note: it is crucial to understand applicable “open door” or “sunshine” laws and be sure there is adequate time for required public notice of meetings.) Our goal for the first meeting was to provide updates on our project work, along with some basic information on Health in All Policies (HiAP), health elements in Comprehensive Plans, and principles of public engagement – tools that can strengthen policy and decision-making (see [Section VIII Appendix B](#).) Our goal for the second meeting was to dive more deeply into these approaches by considering the possible benefits, opportunities, and challenges of each. The second session also allowed officials to brainstorm and explore possible ways to move forward, and then to consider potential initial steps that may lead to new approaches to improve public engagement and community health. To reinforce these concepts, we provided them with a bound set of resources which included examples of public engagement principles and best practices, as well as a guidance document with hyperlinks to examples of HiAP approaches and health elements in comprehensive plans from other communities. (See Section VIII Appendices [C](#), [D](#), [E](#), and [F](#) for materials from the second meeting.)

After these meetings, members of the CVHMC team met with the elected officials who are members of our Advisory Council. We were interested in hearing their reactions to the meetings, their perceptions of their colleagues’ impressions, and their thoughts about how CVHMC might further support their efforts in each jurisdiction and role (City Council, County Council, County Commissioners, Office of the Mayor).

The Logic Model below illustrates how we conceived the work with the elected officials only. At the time of this writing, a member of the County Board of Commissioners is drafting a resolution for the county to adopt a Health in All Policies approach to decision-making. As noted in the Logic Model, the adoption of an alternative approach to decision-making that would necessarily involve inclusive and equitable public participation was one of the goals we sought to achieve.



One of the challenges in our work with elected officials was how to engage them in the first place. It is critical to begin to cultivate relationships with each elected official very early in the project. The concepts may be new to them, and it takes time for people to become open to learning and interested in considering significant changes to the way they conduct their work. Staying in regular touch with elected officials with meaningful interactions is vital to building and maintaining solid connections.

Since we carried out our work during a pandemic, we had Zoom at our disposal. In this case, this was a real advantage. Once we established good working relationships, the primary method we used to invite them to the meetings was by having personal Zoom conversations. It is more powerful and persuasive to talk with someone over a video call than to do so by telephone or email. It has the added advantage of being more time efficient for both parties.

Another important factor in securing their attendance in our two educational sessions was to set the meeting dates and times well in advance, considering such factors as holidays or major government activities (for example, budgeting) that might eliminate blocks of their time. This was important for two reasons: 1) it allowed busy officials to reserve the time on their calendars before they scheduled other commitments, and 2) it allowed us to talk about it with them “early and often,” as they say.

Lastly, we couldn’t be shy. We invited them to join with a direct ask. We also suggested that they put the dates on their calendars rather than assuming they would. We believed that they were more likely to take it seriously if we took it seriously.

“I have always respected the private, public and nonprofit partnerships that were needed to fill need gaps in our community. I would like to examine where some of these partnerships have broken down in meeting the needs of the underserved, including elders and those with disabilities in addition to the general malaise of poverty, working poverty, mental healthcare and racial inequality. A strong economic development strategy also seems to be at the core of many of our social deficits - we need better paying jobs, a focus on quality public education, and a general look at quality of life issues all across the board to improve health outcomes.”

*Meeting reflection by government official*

**PROCESS IN BRIEF:**

**Working with elected officials**

Identify and network with elected officials

Invite elected officials to assume a formal role in the initiative

Facilitate deliberative discussions of the new ideas being brought forward

Conduct ongoing and session-specific evaluation and data analysis

### Questions to spark further thought:

- Does anyone on the project leadership team have a relationship with local elected officials (mayor, city council, city manager, county council, county commissioners, etc.)? If not, how will you build these relationships and bring elected officials into the project?
- Who is/are the gatekeeper(s) to decision-making and policy setting in your local government?
- Are there currently health elements in your community's Comprehensive Plan, or provisions regarding public engagement?
- Is there an existing commitment to a “Health in All Policies” approach to decision-making in city or county government?
- How is public engagement/public dialogue used by elected officials and/or administrative departments currently? Is it used at the start of the decision-making process, or is it brought in later?
- How will you include elected officials in every step of your project?

## Section VIII Appendices Links

Appendix A: Engagement Scan Matrix

<https://tinyurl.com/SecVIIIAppendA>

Appendix B: Elected Officials Meeting Updates and Materials (Meeting 1)

<https://tinyurl.com/Sec8AppendB>

Appendix C: Elected Officials Meeting Agenda and Slides (Meeting 2)

<https://tinyurl.com/Sec8AppendC>

Appendix D: Selected Resources for the Development of Local Health and Public Engagement-Related Plans, Practices, and Policies

<https://tinyurl.com/Sec8AppendD>

Appendix E: Selected Resources for the Development of Local Government Public Engagement Principles, Practices, and Policies

<https://tinyurl.com/SelectedResources>

Appendix F: Selected Health and Health-Related Content from Local Comprehensive Plans

<https://tinyurl.com/Sec8AppendF>

Please use the following QR code to view these resources on our website:



## Section IX: Making Clear Connections and Disseminating Information

In this section:

- Maintaining communication with stakeholders
- Best practices for building trusting relationships with community members
- Building relationships with liaisons to underrepresented communities
- Eliminating barriers to participation

In impacting decision-making so it is more equitable and community-based, one of the most critical components is developing and nurturing strong connections with as many people and institutions across sectors as possible, always with an equity focus.

To build our database, we kept careful track of everyone with whom we had contact of any kind, as well as people and groups we hadn't connected with yet, but that we knew were important to the work. We made concerted efforts throughout the project to maintain communication with these identified stakeholders – sometimes as a large group, sometimes in targeted messaging. Some of our methods were:

- Sending feedback surveys following project activities (see [Section VI Appendix F](#)) along with notes from the meetings to ensure that we had reported their comments correctly
- Inviting participants from previous activities to participate in future activities
- Communicating via personal email messages
- Sending periodic mass updates via Constant Contact email software (see [Section IV Appendix B](#) for an example)
- Developing and disseminating occasional process updates or summary documents (see [Section IX Appendix C](#) for an example)

Solid relationships are crucial to bringing about change. This is an aspect of this work that is easy to let slide but should instead be a key focus. Possibly the most critical aspect of those relationships is trust – particularly with marginalized groups. There are plenty of resources available elsewhere about engaging successfully with underrepresented communities, but it's critical enough that it warrants a few words here as well.

People who society has marginalized are understandably hesitant to “put themselves out there again.” Why would they? They've done it time and time again. At the least it's been fruitless; at worst, it's been harmful or painful. Everyone the project team interacted with needed to believe in our intentions and that we could be trusted. For marginalized groups, this comes slowly. Connecting with people who are usually missing from community conversations and decisions



requires patience, diligence, and relationship-building. This effort takes time and must be made well before the event or activity for which you're asking their participation. If the effort fails, it becomes yet another barrier to any future engagement. Since relationship building happens over time, it should be one of the very first things initiated. Following are some basic principles we applied to developing these trusting relationships:

- When possible, meet people where they are (attend events, visit churches and community centers, and so on); if not, create online options that ensure that everyone can participate.
- If applicable, ask them to help design the event or activity.
- Listen with genuine interest.
- Ask questions with sincere curiosity.
- Show respect and empathy.
- Regard and reward their contributions as true expertise (see [Section IX Appendix D](#) for a sample MoU.)
- Create a safe and non-judgmental atmosphere.
- Reflect back to them what they've said to show that it is valued and heard.
- Follow-up after the event in ways that communicate that their input was received and is being considered.
- In ongoing communication, ensure that they can see how their contribution was heard by and has influenced decision-makers.

The potential for improved processes that are more inclusive and equitable and the opportunity to leave more members of the public feeling positive about public-council interactions excites me.

*Paraphrased from meeting reflection by government official*

Another important component of connecting with these groups is building relationships with people who can serve as liaisons to additional people. They, along with those with whom they help to provide connections, provide a valuable perspective from their lived experiences. For instance, inviting someone who is living in poverty to be a part of your core team allows that person to gain a deep understanding of the work, become solidly committed, and then share what she knows with friends and neighbors. Or having a transgender person involved who can pull together a group of LGBTQ+ people for a facilitated discussion. Trusted advisors and allies within a particular community can make all the difference in building relationships.

## Best Practices for Removing Barriers to Participation:

Hold events in physically accessible locations.

Ensure that activities are accessible by public transit and/or offer to provide transportation.

Offer childcare.

Hold events in a variety of neighborhoods.

Provide a sign language interpreter.

Hold events on varying days of the week and at varying times of day.

Consider possible technology barriers.

Offer stipends to demonstrate that participants' time is valued.

## Questions to spark further thought:

- How will you translate the findings from the discussions into information that you can share with others?
- Who are the audiences for whom communication is needed?
- What methods will you use to communicate with a variety of stakeholders and audiences?

## Section IX Appendices Links

Appendix A: Small Group Discussion Surveys

<https://tinyurl.com/Sec6AppendF>

Appendix B: Constant Contact Email Samples

<https://tinyurl.com/Sec4AppendE>

Appendix C: CVHMC Process Summary Update January 2022

<https://tinyurl.com/Sec9AppendC>

Appendix D: Sample MoU

<https://tinyurl.com/Sec9AppendD>

Please use the following QR code to view these resources on our website:



## Section X: A Study of Cross-Sector Collaboration and its Impact

In this section:

- The formation of the Monroe County Community Health Improvement Plan
- Working with other regional agencies and organizations
- Sharing data with partner organizations
- Hosting a Think Tank event
- Encouraging community participation across sectors

An unexpected opportunity that presented itself to our group was working with and making important contributions to an existing collaborative effort in the community. Every three years, all tax-exempt hospitals are required by the Federal government to carry out a Community Health Needs Assessment (CHNA). At the same time, county health departments that wish to pursue accreditation from the Public Health Accreditation Board conduct their own needs assessment to identify high priority health needs in the community and develop a Community Health Improvement Plan (CHIP). In Monroe County, the hospital and county health department join forces in collaboration with our city's parks department and a local health care provider to carry out these efforts.

The development of the Monroe County CHIP is an extensive process. It includes the comprehensive health needs assessment research mentioned above, with additional resident involvement in the form of a community "Think Tank" to gain input, prioritize the results of the CHNA, and determine the top three health concerns to be addressed by the new plan. Community action teams are then formed around each of the top three priority areas identified by residents in the Think Tank process.

Our community's Health Improvement Plan process is well established, and we are grateful that we were able to contribute to what was already being done. In 2021, CVHMC joined forces with the existing partners in the effort and we were able to have a positive impact on the information gathered and the process used.

Our initial collaboration was developing community health survey questions, as well as planning focus groups to gather resident perceptions of health needs within the community. We also entered into a Memorandum of Understanding which allowed the organizations involved to share data and information as well as to co-host focus group sessions. The groups had reached different populations in their data collection, so sharing our information with each other brought critically important diversity to the results.

Another area in which we contributed to the effort was in helping to enhance the long-standing Community Health Assessment "Think Tank", which has been an excellent way to acquire community input. The Think Tank brings together a diverse group of community members, service providers and decision makers to set priorities for the Community Health Improvement Plan (CHIP) based on the CHA results. We worked with the other collaborators to build on that success and develop a revised facilitation format, broaden the scope of participants involved, and help ensure the sessions were more accessible to a variety of participants. In particular, our team trained facilitators, organized program details, and designed a public engagement process to create opportunities for community members to discuss the topics before moving to the voting and ranking stages. We also provided handouts, topic-specific data-walk posters (see [Section X Appendix A](#)), and a joint PowerPoint presentation (see [Section X Appendix B](#).) The format for the day was designed to provide inclusive and interactive activities for community members in discussing issues, considering what is missing, prioritizing topic areas, and identifying action team members to address those issues (see [Section X Appendix C](#).)

The value of this newly designed process was borne out when a representative of the health department commented about how worthwhile it was to allow time for discussions. As she listened in on conversations around the room, she said she was amazed at the great ideas and thoughtfulness in the participants' conversations. Notetakers captured details from the conversations to be sure that these ideas could be considered for the Community Health Improvement Plan. Please see [Section X Appendix D](#) and [E](#) for examples of the materials prepared for the Think Tank.

Lastly, CVHMC team members helped recruit community members to participate in the action teams, and a member of CVHMC helped deliver a presentation on community health issues at a CHIP kickoff meeting (see [Section X Appendix F](#).) The ideas generated throughout this extensive public engagement process are now a part of this year's community health planning process.

### **Priorities set during Think Tank sessions for creation of CHIP Action Teams**

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- **Poverty and Navigating Health and Social Services**
- **Inequity, Discrimination, and Bias**
- **Substance Use and Mental Health**

## Section X Appendices Links

Appendix A: CHIP Think Tank Data Walk Posters

<https://tinyurl.com/Sec10AppendA>

Appendix B: CHIP Think Tank Slides

<https://tinyurl.com/SecXAppendB>

Appendix C: CHIP Think Tank Meeting Agenda and Facilitation Guide

<https://tinyurl.com/Sec10AppendC>

Appendix D: Community Health Assessment Think Tank Handout

<https://tinyurl.com/Sec10AppendD>

Appendix E: Think Tank Outreach Materials

<https://tinyurl.com/Sec10AppendE>

Appendix F: CHIP and Action Team Materials

<https://tinyurl.com/Sec10AppendF>

Please use the following QR code to view these resources on our website:



## Section XI: Conclusion

Our initiative has been inspirational, challenging, exciting, frustrating, difficult, fun, motivational, and so much more. Any effort to bring about change is going to include all of those experiences. What matters most is whether or not it was worth it. Did it move people to start to think differently about what impacts health and how decisions are made? Did organizers learn what worked and what didn't? Did this learning impact the design of the initiative? Did community members learn new things? Did it deepen understanding between people and groups? Between the community and decisions makers? Did it spark a closer look at the way things have always been done? Did it bring new people to the table? And of course, did policy or practice change occur?

For the CVHMC initiative, one major aspect that we have yet to see the results of is the sustainability of the effort. To facilitate that, we are transitioning our previous advisory council to a "health equity council" that we hope will provide government officials with easy access to communities not typically at the policy-making table so that they are heard from when decisions are being made. We are also hopeful that our efforts with local government officials will result in stronger internal policies and procedures to ensure the inclusion of diverse voice earlier in all policy and program decision-making.

Bringing about this kind of change isn't easy. It takes commitment and persistence. But the rewards can be profound. We hope this toolkit has been helpful to you and that you will find your way to inspiring and facilitating the kind of change you hope to see.

We wish you the very best in your efforts!

### Questions to spark further thought:

- Who will continue to carry your work forward and how will that happen?
- Do you need contracts or binding agreements between entities to ensure stability (for instance, between units of government, or between government and stakeholder representatives)?
- What methods will you use to communicate with a variety of stakeholders and audiences?



Please feel free to contact the Robert Wood Johnson Foundation for additional insights and information at <https://www.rwjf.org/>.

And for more information about Community Voices for Health in Monroe County:

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