Community Engagement Guide
STATEWIDE HEALTH IMPROVEMENT PARTNERSHIP (SHIP 4)
COMMUNITY ENGAGEMENT GUIDE

Community Engagement Guide
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Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording.
NOTE: Content in this guide is subject to change. Watch Basecamp for news on any updates.
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Overview

Community engagement is a type of public participation that involves groups of people in problem-solving and decision-making processes. It is a multifaceted, ongoing process.

The Centers for Disease Control and Prevention (CDC) defines community engagement as “the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests or similar situations with respect to issues affecting their well-being.”

Community engagement is a strong value and fundamental practice of public health. The importance of engaging the community is grounded in the belief that the public has a right to participate, that the public has valuable knowledge about what will work in their own communities to improve health and that the public can make good decisions. Together public health expertise and community “collective intelligence” will more accurately identify problems and develop more elegant and effective solutions.

This guide:

- Highlights renewed calls for strengthening the capacity of public health to engage the community for improved population health.
- Provides a glossary of common terms.
- Links SHIP activities to community engagement.
- Highlights some considerations for building strong partnerships in the context of SHIP.
- Outlines technical assistance and training that will be available to support SHIP grantees in strengthening skills for community engagement.
Background

While engaging the community has long been part of public health practice, renewed calls for deeper and sustained engagement are coming from national organizations such as the Institute of Medicine (IOM) and the Public Health Accreditation Board (PHAB). A recent IOM report identifies “mobilizing the community and forging partnerships to leverage resources” as a foundational capability for public health departments. It calls for health departments to develop the ability to work in sectors outside of health to achieve and broaden impact.ii

PHAB has set national standards for the community health assessment and improvement planning process that include the community throughout the collection and analysis of data and the priority setting and strategy-development processes. These standards include an expectation that communities will remain involved in the implementation, monitoring and updating of the plan over many years.iii PHAB also emphasizes that community engagement has benefits of strengthening social engagement, building social capital, establishing trust, ensuring accountability and building community resilience.

Communities and populations who are able to influence decisions so that there are positive impacts to their living conditions are healthier – so the way we do our work and who we do it with does make a difference.

In Minnesota, the Healthy Minnesota 2020 Statewide Health Improvement Framework also prioritizes stronger, more effective community engagement. One of its three themes is to “strengthen communities to create their own healthy futures.” This theme reflects the fact that individuals are never healthy—or unhealthy—alone. Individual and collective actions together create the environments that play such an important role in health and well-being.iv Community engagement is a core component of any and every effort that seeks to develop collective action and build community capacity to create a healthy future for all.

Community engagement efforts in public health should:

- Generate new leadership and build effective relationships among community members and systems leaders.
- Identify specific objectives, use data well and develop meaningful ways to measure outcomes.
- Increase community awareness of what creates health and provide mutual experiences of how partnerships lead to shared success.

Engaging the community requires a set of skills that can be developed. But it also requires the knowledge and conviction that the community has a right to participate, has valuable knowledge about what will work in their communities to improve health and has the ability to make good decisions. When convening diverse voices to make decisions to improve health, public health organizations must operate out of these beliefs and understanding because engaging the community in SHIP is challenging, will surface conflicts and takes time. But ultimately, the community working together can develop meaningful solutions, leverage community resources to create impact, and develop leaders who will advocate successfully for the long-term health of their families and communities.
Terms

This is a list of common terms related to community engagement:

**Community:**
Community is a group of people who have common characteristics or shared identity; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds. Ideally, there would be available assets and resources, as well as collective discussion, decision-making and action.v

**Community engagement:**
The Centers for Disease Control and Prevention (CDC) defines community engagement as "the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests or similar situations with respect to issues affecting their well-being."vi

**Authentic Community Engagement:**
While the words “authentic engagement” are often used, there does not seem to be a commonly shared definition of authentic engagement. MDH and SHIP grantees have developed a set of authentic engagement principles designed to guide engagement work so that trust is fostered, solutions are co-created with communities, and ability of public health departments and communities to create healthy futures for all people in Minnesota are strengthened. (See Appendix B)

**Collaboration:**
Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards.vii

**Coalition:**
A coalition is an organized group of people in a community working toward a common goal. The coalition can have individual, group, institutional, community, and/or public policy goals.viii

**Community mobilization:**
Community mobilization is the act of engaging all sectors of a community in a community-wide effort.ix

**Community organizing:**
Community organizing is the process of building power through involving a constituency in identifying problems they share and the solutions to those problems that they desire; identifying the people and structures that can make those solutions possible; enlisting those targets in the effort through negotiation and using confrontation and pressure when needed; and building an institution that is democratically controlled by that constituency that can develop the capacity to take on further problems and that embodies the will and the power of that constituency.x
**Health Disparity:**
A population-based difference in health outcomes (e.g., women have more breast cancer than men).

**Health Equity:**
When every person has the opportunity to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

**Health Inequity:**
A health disparity based in inequitable, socially-determined circumstances (for example, American Indians have higher rates of diabetes due to the disruption of their way of life and replacement of traditional foods with unhealthy commodity foods). Because health inequities are socially-determined, change is possible.

**Health in All Policies:**
Health in all policies is a collaborative approach that integrates and articulates health considerations into policymaking across sectors, and at all levels, to improve the health of all communities and people. Health in all policies focuses on changes in the systems that determine how policy decisions are made and implemented by local, state and federal government, to ensure that policy decisions have neutral or beneficial impacts on the determinants of health. Health in all policies emphasizes the need to collaborate across sectors to achieve common health goals, and is an innovative approach to the processes through which policies are created and implemented.

**Populations experiencing health disparities:**
Populations experiencing health disparities are populations with differences in overall rates of disease incidence, prevalence, morbidity, mortality or survival. In addition, these populations face barriers to access and participation in SHIP strategies due to their social, demographic and economic characteristics, and/or have been identified by SHIP grantees as specific populations most at risk of health disparities and inequities.

Populations experiencing health disparities are comprised of people with certain characteristics that cause them to be at greater risk of having poor health. MDH considers these characteristics to include, but are not limited to: age, culture, disability, geographical location, immigrant status, race/ethnicity, refugee status, socio-economic status and sexual orientation. Most often there is an overlap between different populations categorized as experiencing health disparities; for example, the over-representation of a particular racial/ethnic group in a lower SES or geographical location.

**Structural racism:**
Structural racism is the normalization of an array of dynamics — historical, cultural, institutional and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians. Structural racism is deeply embedded in American society and is a potent factor leading to inequities in all major indicators of
success and wellness. Structural racism is perpetuated when decisions are made without accounting for how they might benefit one population more than another, or when cultural knowledge, history and locally-generated approaches are excluded. When this happens, programs and policies can reinforce or compound existing race-based inequities.
Community Engagement within the Context of SHIP

The SHIP state statute require that grantee activities be based on community input and address the health disparities and inequities that exist in the grantee’s community.

This guidance focuses on points of engagement to involve community members in the creating healthier communities:

1. Engaging the populations on which health improvement efforts are focused.
2. Engaging the communities experiencing health inequities.
3. Building partnerships to advance SHIP strategy work.
4. Establishing and maintaining strong Community Leadership Teams.

Community Engagement and Health Equity

The community engagement recommendations in the MDH 2014 Advancing Health Equity in Minnesota report call for a broadened scope of partnerships to develop stronger connections with Minnesota’s diverse communities – especially those populations most affected by health inequities.

MDH and grantees work to create avenues for those from affected populations to have meaningful participation in SHIP work. This may include co-creating a work plan with a community organization, investing staff time and resources in building community partnerships and involving diverse communities in decision-making opportunities. Community Leadership Team (CLT) membership should include those from impacted populations and CLT agendas should include opportunities to influence programmatic decisions and discussions of the key social conditions that influence the opportunity for health within a grantee’s jurisdiction.

Health equity work is based on community needs, which may differ across the state. SHIP grantees work with a range of populations experiencing health disparities. The characteristics of these communities include but are not limited to: age, race/ethnicity, culture, disability, gender, geographical location, immigrant status, refugee status, socio-economic status and sexual orientation.

Often decisions are made without accounting for how they might benefit one population more than another, or when cultural knowledge, history and locally-generated approaches are excluded. When this happens, programs and policies can reinforce or compound existing race-based and other inequities. MDH developed a set of questions to consider when to trying to intentionally develop policy and processes that advance equity. These questions may be helpful as you consider how to advance equity through the implementation of SHIP. See Appendix E
Working with populations/communities that are the focus of PSE change efforts

There are multiple reasons to work with populations or communities that are the focus of PSE changes efforts including strengthening community buy-in, increasing the impact and sustainability of PSE changes, and leveraging community knowledge and relationships.

For example, there may be opportunities to engage seniors in developing active living plans focused on increasing the activity of senior residents; to engage multi-unit housing residents in smoke-free policy development or to engage students in school based healthy-eating changes.

Engaging populations experiencing health inequities in PSE change

Grantees are engaging populations experiencing health inequities in SHIP activities to varying degrees. For some this has become a regular part of the work and for others this is a new area of effort. The SHIP statute requires that grantees “address the health disparities and inequities that exist in the grantee’s community.” MDH is learning along with grantees how to conduct these engagement efforts most effectively.

In year one of SHIP 4, grantees are being asked to conduct a health equity analysis for their jurisdiction. Part of this analysis needs to be done with members of the communities experiencing health inequities. This will lay the ground work and build relationships for engaging populations in choosing and implementing PSE changes in subsequent annual work plans.

While some activities - like the grantee story to the left - may address the health outcomes of inequities, the SHIP 4 required health equity analysis will include identification of the root causes of inequities. MDH along with grantees will consider how SHIP activities and Community Leadership Teams may be able to address root causes.
Partners in SHIP settings

Health departments are working with multiple site partners to implement the SHIP activities and to achieve the goals and broaden the impact of the SHIP program. Engagement of schools, workplaces, clinics and communities connects the partners’ organizational relationships and knowledge with public health expertise to increase effectiveness. These partnerships may be able to leverage organizational resources to increase impact.

SHIP staff have an opportunity to work with these partners to engage the populations or communities that are the focus of the joint PSE work. SHIP staff can engage these partners in discussions of health inequities in their communities and build a common commitment to advance equity.

Letters of commitment are a useful tool to clearly outline the responsibilities of each partner. These letters should confirm the commitments of each partner and state the SHIP goals that the partnership is supporting. These letters can also outline the ways that the partners will engage the populations/communities that are the focus joint PSE work and what health inequities are being addressed.

**Grantee Story:** Downs Food Group (DFG) partnered with Watonwan County PH and Madelia Community Hospital to employ a bilingual health educator for DFG’s workplace wellness program. Vending machines within the plant now offer more nutritious options and along with tobacco-free grounds policy, there is cessation support for employees.
Further Guidance on Community Engagement

Community engagement is a multifaceted, ongoing process. There are various ways to engage the community and different levels of engagement. This breadth and depth of options can make figuring out where to start engaging the community overwhelming.

Once started, community engagement efforts also require sustained attention. Organizational infrastructure, financial and human resources, and staff skilled in engaging individual community members and groups are needed.

This guidance focuses on a handful of topics to support grantees as they develop work plans for SHIP 4. There are many resources for supporting community engagement including a number listed at the end of this guidance.

This section covers three topics:

1. Community Leadership Teams
   a. CLT Leadership Principles
   b. CLT Core Roles
   c. Recruiting CLT members
2. Authentic Engagement
3. Levels of Engagement

Community Leadership Teams

The design of the Statewide Health Improvement Partnership relies on harnessing the strengths and resources of multiple community partners to advance policy, systems and environmental changes as a way to create conditions and sustainable leadership that will support the health of all people in Minnesota.

A high functioning Community Leadership Team represents a critical backbone structure for local SHIP work. CLT’s can:

- Provide direction and support for the work of SHIP
- Ground and advance the work of SHIP in their communities
- Create vital connections between SHIP and other work
- Assure accountability to the community – answering the question: Is SHIP making a difference?

The formation and support of CLTs represent a valuable opportunity to engage a diverse set of stakeholders to create and advance health in their communities. Community leadership teams are fertile ground for tapping into, building leadership for health. We must constantly be asking if we have the right people at the table and if we are truly engaging them – so we can fully benefit from what they can bring to the table – unique perspective, expertise, community connections to other work in the community, energy and support for SHIP work.
In the second half of 2015, MDH staff reviewed information collected about community leadership teams during SHIP 3. Results of an analysis of this information have been and will be shared with grantees. During the first year of SHIP 4, CLT evaluation measures will be determined with input from grantees. More information and support for gathering and reporting CLT evaluation data will be provided as it becomes available.

CLT Core Roles:

In 2014, MDH staff, grantees and community leadership team members worked together to answer these questions:

- What are the core roles of the CLTs?
- What does it mean to be leaders for health in a community?
- How can the CLT advance a vision of a healthy community and support the development of the conditions that create health?

They identified five core roles for CLT members, put forward a set of three leadership principles, and identified some areas where technical assistance and training could support the core roles and leadership principles.

The next two sections outline the leadership principles and the five core roles. The entire Community Leadership Team Framework document is included as Appendix C and includes examples of the leadership principles and core roles.

Community Leadership Team: Leadership Principles

Community Leadership Teams should be providing leadership for health in all Minnesota’s communities. The team that developed these principles were informed by a model developed by Public Allies and its belief that “leadership is an action many can take, not a position few can hold.” (For more detailed information see Appendix C.)

- Leadership Principle #1: Leaders take responsibility to work with others on a common goal.
- Leadership Principle #2: Leaders practice values that make them credible and effective.
- Leadership Principle #3: Leaders learn new knowledge and skills to support achievement of the shared goals.

Community Leadership Team: Core Roles

In SHIP 3, grantees submitted charges for CLTs with their applications. The team that developed the five core roles for CLTs looked at the 42 different roles described in these charges as a starting point. They developed the following list of five core roles for CLTs.
This is not meant to be prescriptive as each grantee should determine the roles and leadership definition for its own CLT, but to provide a starting place and focus for technical assistance and training. (For more detailed information see Appendix C.)

- Core Role #1: Advisor/Decision Maker
- Core Role #2: Connector/Networking
- Core Role #3: Articulator of a shared and inspiring vision
- Core Role #4: Advocate
- Core Role #5: Monitor: Holding the effort accountable to the shared goals and values

Just a note on advising and decision-making: Authentic Engagement Principles #12 states: “Share power. Be ready to share power with communities, and be flexible and creative to meet changing challenges. Reflect on the benefits that come from shared decision-making in strong partnerships.” Consider what kinds of decisions your CLT can make. Share options for activities and ask your CLT to prioritize. Try to include one decision making item on each CLT agenda – this will help the CLT members experience the importance of their participation.

Consider having a discussion of these leadership principles and roles when reviewing and updating the charter with your CLT. Contact the SHIP community engagement specialist or your community specialist for a list of discussion questions.

Community Leadership Teams: Membership Recruitment

Whether you are establishing a new CLT or recruiting new members, know that there are many people who care about the health and well-being of all people in your community. So how do you identify and recruit members to participate in the CLT?

To start, you can:

- Create a list of the kinds of partners needed and work with staff or existing community team members to identify specific individuals or groups to approach. You might map the current members first to see where you might have gaps.
- Consider assets and resources in the community that you may want to tap, and identify the specific individuals or organizations to approach.
- Meet with people that know and support SHIP work and ask them for suggestions.
- Consider decision makers in your community that could support SHIP efforts.
- If you do not know anyone from the populations experiencing health disparities you have identified, ask someone who knows you to facilitate introductions.

Once you have created a list, consider the best mix of people to bring together to improve the health of the community. Develop your ideal list of participants. Not everyone will say yes, so have one or two back-up members identified for each slot.

Once potential partners are identified, the process of establishing relationships and seeking commitments for participation begins. This is a process of developing mutual respect, understanding and trust.

- Before meeting with people, prepare for the meeting by consider the authentic engagement principles in the “foster trust” section.
• Set individual in-person meetings at a location convenient for them, to explore whether membership on the CLT is a good fit.
  o Potential members have to represent their organizational interests, but they also have personal interests. Try to find out if they have a personal passion for creating the conditions that ensure health is available to everyone in your community.
  o Be clear about their role what you are asking them to initially commit to – your “asks.” The CLT’s draft charge should be shared with potential members. Also be clear about how long you would like people to serve. As SHIP continues some people will need to and probably should rotate off the CLT.
  o Potential members may need to see the benefits of participating. Be prepared to share a list of the benefits. Your current CLT members may be able to help you identify these benefits.
• Be clear about the level of engagement from the chart on the next page (outreach, consult, involve, collaborate or share leadership) that your health department can commit to. Potential participants may have experienced other community engagement processes that promised a level of involvement that was not realized.
• Be clear about the level of authority and decision-making your CLT will have.

Authentic Engagement

What does it mean to “authentically” engage the community? While the words “authentic engagement” are often used, there does not seem to be a commonly shared definition of authentic engagement. But authentic implies that our efforts should be genuine.

A set of authentic engagement principles (Appendix B) are designed to guide community engagement efforts. They are grounded in the CDC Principles of Community Engagement and informed by the Public Health Accreditation Board standards and measures. They have been further refined through discussions with SHIP grantees, MDH staff, training and technical assistance providers, and the experience of MDH community engagement and Voices for Racial Justice staff.

These principles are divided into three sections:

- Foster trust
- Support community-led solutions – ensure the population impacted by the problem is involved in co-creating solutions
- Public health improvement requires social change

Consider these as a guidance community engagement, not as a check list of everything that should be done. It may be that a few of these are most relevant for particular engagement efforts.
Level of Engagement

One way to assess community engagement efforts is to consider the nature of communication, information flows, partnerships and decision-making structures that currently exist between a grantee and the community.

Consider the level of engagement (as in the chart below) of your health department’s previous and current community engagement efforts, and if it is ready and willing to move into a deeper level of engagement. Ultimately, reaching the shared leadership level can give all parties ownership in the final outcome and can contribute to the sustainability of health improvement efforts.

Chart from Principles of Community Engagement, 2011, Page 8
Training and Technical Assistance

Grantees must budget for at least one staff to attend three regional in-person trainings and one two-day statewide meeting per year. Community engagement topics will be incorporated into these trainings and meeting. Announcements on trainings and meetings will provided in the Making it Better Log.

Support for the development and strengthening of CLTs will be offered. If you have questions or concerns about CLTs, phone coaching and technical assistance is available from SHIP community engagement staff. Content and setting specialists have identified opportunities for engagement in SHIP activities related to the menu of strategies. For more information, contact your community specialist. They can connect you with further resources or support.
Resources

This is a short list of resources on community engagement and coalition building. Hyperlinks to these documents and web pages are embedded in the underlined portion of the description.

9 CDC Principles of Community Engagement

This is a quick view of the principles of community engagement from CDC/ATSDR Principles on Community Engagement, 2nd Edition, (2011). There is a link to the entire document at the bottom of the web page. This primer can serve as a guide for understanding the principles of community engagement for those who are developing or implementing a community engagement plan. It provides a fuller understanding of community engagement to facilitate and promote the use of community engagement to advance the health of all communities.

Advancing Health Equity Report

The Advancing Health Equity in Minnesota: Report to the Legislature was submitted to the Minnesota Legislature on Friday, Jan. 31, 2014. The report assesses Minnesota’s health disparities and recommends best practices, policies, processes, data strategies and other steps that will promote health equity for all Minnesotans.

Best Practices for Comprehensive Tobacco Control Programs: Coalitions

This resource focuses on the critical role coalitions play in a comprehensive tobacco control program. According to best practices, communities need to work toward transforming the knowledge, attitudes, and practices of users and nonusers by changing the way tobacco is promoted, sold and used. From the CDC

Building the Case for Racial Equity in the Food System

The food system works for some, but fails too many of us. We have a glimpse of the possibility of a just and healthy food system. To get there, we must use a critical race lens to diagnose what is wrong with our current system, assess entry points for change and determine ways that we can work together to build a better system for all of us. This report shares an analysis of what it means to build a racially equitable food system – from field to farm to fork – and lays out steps toward achieving that goal.

Building the Field of Community Engagement

Building the Field of Community Engagement is a Minnesota collaborative initiative designed to magnify and elevate the power of community engagement to change the way problems are solved and resources are invested. While this effort is relatively new, the website includes a number of useful publications and tools.

The Community Tool Box

The Community Tool Box is a global resource for free information on essential skills for building healthy communities. It offers more than 7,000 pages of practical guidance in creating change and improvement.
Core Competencies for Public Health Professionals – Community Dimensions of Practice

The Council on Linkages Between Academia and Public Health Practice's Core Competencies for Public Health Professionals (Core Competencies) were designed for public health professionals. The Core Competencies are a set of skills desirable for the broad practice of public health, reflecting the characteristics that staff of public health organizations may want to possess as they work to protect and promote health in the community (i.e., deliver the Essential Public Health Services). See the section on Community Dimensions of Practice to see a set of community engagement skills.

Developing Effective Coalitions and Eight Step Guide

This step-by-step guide to coalition building helps partnerships launch and stabilize successfully. It supports advocates and practitioners in every aspect of the process – from determining the appropriateness of a coalition to selecting members, defining key elements, maintaining vitality, and conducting ongoing evaluations. From the Prevention Institute

Healthy Minnesota 2020 Statewide Health Improvement Framework

The framework features three themes that reflect the importance of social and economic determinants for health: capitalize on the opportunity to influence health in early childhood; assure that the opportunity for health is available everywhere and for everyone; and strengthen communities to create their own healthy futures.

MAPP – Organize for Success/Partnership Development

Mobilizing for Action through Planning and Partnership is a community-driven strategic planning process for improving community health. This guidance on the first phase of MAPP – organizing the planning process and developing the planning partnership – provides some information that can be applied to CLT planning and development.

The Role of Community Culture in Efforts to Create Healthier, Safer, and More Equitable Places: A Community Health Practitioner Workbook

This workbook draws on the experiences and lessons of numerous communities working to advance place-based prevention efforts. It is designed to guide community health practitioners who want to learn more about the role of community culture in environmental change efforts. The workbook includes:

- Community Profiles. Provides examples of organizations and initiatives that have placed community culture at the core of their work.
- Guided Questions. Lists key questions and considerations to help practitioners design effective policy, systems, and environmental improvement initiatives that acknowledge and reflect the community's culture.
- Key Resources. Shares resources, toolkits, websites and a glossary that provides further information regarding the role of community culture.
SHIP 4 Requirements for Community Engagement

Work Plans

In SHIP 4, grantees are encouraged to devote staff time to building community partnerships – from establishing new relationships to building and maintaining partnerships.

Work plans should reflect the time needed for community engagement activities. SHIP community engagement staff and community specialists can help with identifying activities and estimating time to complete these activities.

Please see a milestones documents in Appendix D. This document highlights some of the activities, gives estimated times and end products from a variety of engagement activities.

Community Leadership Team

Applicants must have a Community Leadership Team (CLT) and complete the CLT Form.

Applicants must submit a current charge or charter for their CLT. Grantees should review their charge/charter annually with their CLT and submit any future CLT charge/charter changes to MDH. A template for the leadership team charge is located in Appendix A.

Community Leadership Team Membership

Applicants are encouraged to have CLT members from their jurisdiction who are from the populations who experience health inequities or disparities.

Applicants should learn about other similar grant work in their community and identify possible areas for collaboration or if these grantees might be interested in serving on the CLTs. Grantees may request technical assistance from MDH staff on how to conduct one-on-one meetings or connecting with other similar grantees in their area.

MDH strongly recommends that applicants who have Tobacco Free Communities grantees, Eliminating Health Disparities Initiative grantees, ClearWay Minnesota grantees, Blue Cross Blue Shield Tobacco Prevention and Control grantees and/or other relevant grants in their area conduct one-on-one meetings with such grantees prior to submitting their SHIP 4 application.

Grantees are also encouraged to consider membership groups – such as AARP, Land Stewardship Project, ISAIAH, YWCA, etc. – that have a large base of members and share goals with SHIP.

Grantees must work to identify community groups and other partners in their area beyond the grantees listed above to serve as CLT members and partners in SHIP work.
Appendix A: Community Leadership Team Draft Charge

Community Leadership Team Draft Charge

3 PAGE LIMIT, 12 PT FONT, DOUBLE-SPACED

Instructions are in italic, red font. Please delete this text as you prepare your draft charge.

Insert CHB or partnership name here

Community Leadership Team

Draft Charge

THE STATEWIDE HEALTH IMPROVEMENT PARTNERSHIP

The purpose of the Statewide Health Improvement Partnership (SHIP) is to improve the health of all Minnesotans and thereby decrease health care costs through increased physical activity, healthier eating, and less use and exposure to commercial tobacco products. SHIP succeeds by encouraging and supporting healthy living and addressing health disparities through community engagement, local decision-making and sustainable, evidence-based strategies.

SHIP is dedicated to helping Minnesotans live longer, healthier lives by preventing the key risk factors for chronic disease. SHIP will contribute to the following goals, which are part of the Minnesota 2020: Chronic Disease and Injury Plan:

- Increase the number of adults who are a healthy weight from 38% to 47% by 2020.
- Increase in the prevalence of youth who eat the recommended number of fruits and vegetables daily from 18% to 30% by 2020.
- Increase in the prevalence of youth meeting moderate physical activity guidelines from 74% of boys and 68% of girls to 92% of boys and 89% of girls by 2020.
- Decrease in young adults (18-24) who smoke from 27.8% to 18.6% by 2020.

In FY 2015-16, the Minnesota Legislative approved an appropriation of $35 million for SHIP.

Add, if desired, a paragraph about local SHIP history and efforts
COMMUNITY LEADERSHIP TEAM PURPOSE AND CHARGE

The purpose of the Insert the name of your CHB or collaboration Community Leadership team is (Insert the purpose statement a purpose statement that is specific to your efforts.)

The Insert the name of your CHB or collaboration Community Leadership Team will:

- Insert a bulleted list roles that your Leadership Team will play. See Appendix which outlines the core roles for leadership teams. Note that this list will change as the CLT develops.

MEETING SCHEDULE

The Insert the name of your CHB or collaboration Community Leadership team will meet:

Insert anticipated schedule of meetings for the CLT. Will they meet monthly? Quarterly? If scheduled, specific dates could be listed.

Insert additional sections or requirements as needed.
Appendix B: Authentic Engagement Principles

What does it mean to “authentically” engage the community? While the words “authentic engagement” are often used, there does not seem to be a commonly shared definition of authentic engagement.

The following principles were developed to guide community engagement work. They are grounded in the CDC Principles of Community Engagement and informed by the Public Health Accreditation Board standards and measures. They have been further refined through discussions with some MDH grantees, staff, training and technical assistance providers, and the experience of MDH community engagement staff and Voices for Racial Justice.

When conducting community engagement, consider these as set of principles to guide the work – not as a check list of everything that should be done. It may be that a few of these are most relevant for particular engagement efforts. Please note: these are not final and suggestions for additions, changes and edits are welcome. Please send them to Jeannette Raymond – Jeannette.raymond@state.mn.us.

**Foster trust**

1. *Immerse yourself in the community,* “establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders” to co-create (create together) solutions. – CDC Principles of Community Engagement

2. *Listen deeply.* Listening can uncover key community concerns, allow for rarely heard voices to be included, build understanding, generate new solutions and build the foundation for collaborative action.

3. *Recognize different kinds of groups.* People self-organize. For instance, communities organically organize beyond community-based organizations (e.g. soccer league, faith communities, barbershop patrons, farmers market vendors, walking groups, retirees who gather daily at the local café, student councils, etc.)

4. *Understand the historical context* of previous attempts of engagement. What are the stories of success, lessons learned, barriers and tensions?

“Relationships we develop with our coalition partners must be transformative, not transactional.” -- Reverend Dr. William Barber
5. **Notice assets.** Sustain efforts and support community ownership by using an asset approach, where community power and strengths are at the base of the work and the tool to develop capacity within communities and within your organization.

6. **See different experiences.** Recognize, respect and appreciate the diversity/differences within and across communities. Awareness of the factors impacting communities’ ability to exercise their power (like historical trauma, oppression, disenfranchisement, etc.) must be intentionally addressed while co-creating, planning, designing and implementing approaches to engage a community.

**Support community led solutions – ensure the population impacted by the problem is involved in co-creating solutions**

7. **Work with communities.** The goal of authentic community engagement is to work WITH communities NOT FOR, on behalf of, or to do things TO communities.

8. **Agree on the process.** The expectations, values, purpose, and role of both the institutions/systems and the stakeholder communities should be discussed and negotiated at the very beginning of any engagement process.

9. **Understand each partner’s individual and community interests.** All partners should be able to identify why they are at the table and the constituencies they are connected with. A partnership will benefit when all partners have relationships with other members of their community.

10. **Allocate resources** for community members to be active participants, so that community engagement is valued for its contribution to the process (e.g., offer stipends, child care, food, interpreters).

11. **Balance power.** Stakeholders should be aware of any working assumptions and of power dynamics and how they impact the development, sustainability and success of partnerships. They should be intentional in addressing power imbalances especially those affecting the ability of the community to act as an equal partner.

12. **Share power.** Be ready to share power (release control of actions and/or interventions) with communities, and be flexible and creative to meet changing challenges. Reflect on the benefits that come from shared decision making in strong partnerships.

13. **Create positive experiences of contribution.** Communities who are able to influence decisions so that there are positive impacts on their living conditions are healthier. Reflect back to participants how their participation has made a difference.
14. **Recognize the contributions** of the community. Publicly share the contributions of community partners when sharing success stories.

**Public health improvement requires social change**

15. **Leave the community stronger.** Ensure that engagement efforts are designed to strengthen the community. Ask the community to define the improvement or how the process can strengthen their community.

16. **Stay in it for the long term.** Community collaboration requires long-term commitment by organizations involved and their partners. Note that some public health work might be project based, but that the department will exist over time. The end of a particular project may not mean the end of engagement opportunities with other public health department activities.

17. **Address racism.** Authentic community engagement intentionally addresses issues of race, institutional and structural racism, discrimination and exclusion, and embodies “cultural humility.”

18. **Remember that self-determination is a right.** “Remember and accept that collective self-determination is the responsibility and right of all people in a community. No external entity should assume it can bestow on a community the power to act in its own self-interest.” - *CDC Principles of Community Engagement*

19. **Expect tension.** Partnership in a change process will sometimes result in tension. Partners will challenge and hold each other accountable for staying true to principles for engagement and to shared goals to improve the opportunity for health.

20. **Address challenges.** Develop a plan to address conflict, being intentional and strategic to transform challenges into opportunities.

21. **Welcome new accountabilities and opportunities to transform practice.** Prepare to be held accountable by new partners for a new set of expectations. These expectations may add complexity to your work, but they also demonstrate that community members value public health work and have a vision of how it can contribute to the issues their communities face.

22. **Strengthen relationships among participating groups to build power for change.** Intentionally find ways to strengthen relationships and mutual accountability among partners, setting the stage for future cooperative efforts to strengthen the conditions that create health.
Appendix C: Community Leadership Team Framework

The Statewide Health Improvement Partnership (SHIP) relies on harnessing the strengths and resources of multiple community partners to advance policy, systems and environmental changes (PSE) as a way to create conditions that support the health of all people in Minnesota. Each grantee is required to have a Community Leadership Team (CLT) that provides support for local PSE work to reduce obesity and tobacco use.

But what are the core roles of the CLTs? What does it mean to be leaders for health in a community? How can the CLT advance the vision and mission of SHIP? What kind of technical assistance and training is needed to support CLT members and the staff who coordinate these leadership teams?

In 2014, MDH staff, grantees and Community Leadership Team members worked together to answer these questions. They identified five core roles for CLT members, put forward a set of three leadership principles, and identified some areas where technical assistance and training could support the core roles and leadership principles.

This document reflects the outcomes of these discussions. This is not meant to be prescriptive – each grantee can determine the roles and leadership definition for its own CLT – but to provide a starting place and focus for technical assistance and training.

Leadership for Health

The first two leadership principles were adopted from a model developed by Public Allies. Public Allies is grounded in the conviction that “leadership is an action many can take, not a position few can hold.” They believe that everyone can make a difference and can work to inspire others to believe in themselves, step up and act. The third leadership principle was lifted up during the 2014 discussions.

Leadership Principles

1) Leaders take responsibility to work with others on a common goal. For example:
   - Leaders work with, not “for” or “on behalf” of communities.
   - Leaders work well with others.
   - Leaders think beyond their own organization’s goals and interests.
   - Leaders are aware of power and privilege and are accountable for who is at “the table” - diversity and inclusions are actions, not ideas.
   - Leaders build trusting relationships so that addressing tensions or conflicts is constructive and can lead to creative innovation.

2) Leaders practice values that make them credible and effective. For example:
   - Leaders listen.
   - Leaders recognize current assets.
   - Leaders sustain efforts by mobilizing community assets and strengths and by developing the community’s capacity and resources to make decisions and take action.
   - Leaders hold the effort accountable to its goals.

3) Leaders learn new knowledge and skills to support their work towards a common goal. For example:
   - Leadership development
   - Power and asset mapping
   - Policy, systems and environmental change
   - Quality improvement
   - Strategic questioning
   - Legislative process
## Five Core Roles for Community Leadership Teams

*Leadership is an action many can take, not a position few can hold.*

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Advisor/Decision Maker** | - Bring and share their discipline’s perspective  
- Prioritize and help to focus the work  
- Identify additional opportunities or approaches  
- Facilitate bidirectional communication – from SHIP to the community, from the community to SHIP |
| **Connector/Networking** | - Understand each partner’s role  
- Network – build relationships and alliances  
- Consider who is missing and identify potential partners  
- Build on community assets and strengths  
- Connect SHIP to people and resources  
- Leverage connections to advance SHIP goals |
| **Articulator of a shared and inspiring vision** | - Speak about the efforts in a positive light  
- Publicly represent the effort  
- Communicate within personal and professional realms  
- Promote the vision and mission |
| **Advocate** | - Speak to decision makers and policy makers at the local and state level  
- Promote policy, systems, and environment change for health  
- Aligning programmatic efforts with PSE changes  
- Support SHIP program  
- Provide flexibility to advocate as some partners are restricted |
| **Hold the effort accountable to the shared goals and values** | - Ask good and sometimes hard questions |

<table>
<thead>
<tr>
<th>Tools for SHIP Coordinators and CLTs</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Advisor/Decision Maker** | - Develop range of brainstorming facilitation tools  
- Conduct power mapping  
- Conduct asset mapping  
- Provide options for CLTs to consider  
- Facilitate prioritization  
- Determine how to get community input |
| **Connector/Networking** | - Structure questions to get feedback from the community  
- Support CLT members to do one-on-ones  
- Support CLT members to do networking in group setting |
| **Articulate a shared and inspiring vision** | - Develop a vision with CLT members  
- Prepare CLT members to present on SHIP vision and efforts  
- Prepare CLT members to speak with the media at events |
| **Advocate** | - Prepare CLT members to advocate with decision and policy makers for local policy, systems, and environment changes for health  
- Connect CLT members to related advocacy efforts (statewide partnering organizations around transportation, tobacco, etc.) |
| **Hold the effort accountable to the shared goals and values** | - Develop shared goals  
- Develop shared values |

Grantees with established CLTs reflected the need for other technical assistance on topics such as refreshing membership, re-energizing CLT meetings, and other issues related to long-standing groups.
| Evaluate what went right, what could have gone better and what could be done differently | Engage CLT members in performance monitoring |
| Learn from failures | Engage CLT members in quality improvement activities |
| Celebrate successes |  |
## Appendix D: Community Engagement Milestones

Building and strengthening relationships as a foundation for new partnerships

<table>
<thead>
<tr>
<th>Prepare for outreach</th>
<th>1.1 Define the population you are trying to reach and clarify the purpose of outreach</th>
<th>1+ hours</th>
<th>Written paragraph describing focus population</th>
<th>Can be done in consolation with others, population choice may be determined by the health equity assessment or other data (your LPH Community Health Assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optional but helpful</td>
<td>1.2 Develop a power map of people within the PH department or county government</td>
<td>1 hour</td>
<td>Power map</td>
<td>CSs can facilitate a power mapping session if needed</td>
</tr>
<tr>
<td>Optional but helpful</td>
<td>1.3 Hold 3-4 one-on-ones with internal staff to identify and develop support; to ask about past history with the particular community; to identify</td>
<td>2.5 hours per meeting – includes preparation, holding the meeting, and record information from one-on-one meeting</td>
<td>Completed recording sheet</td>
<td>Possible questions from the Prevention Institute’s Role of Community Culture in Efforts to Create Healthier, Safer and More Equitable Places</td>
</tr>
<tr>
<td>1.4 Develop a power map of people/organizations from the defined population</td>
<td></td>
<td></td>
<td>Power Map</td>
<td>CSs can facilitate a power mapping session if needed</td>
</tr>
<tr>
<td>Step</td>
<td>Description</td>
<td>Time</td>
<td>Notes</td>
<td></td>
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<tr>
<td>1.5 Identify a group of potential people to meet with</td>
<td>List with names, contact information and connection</td>
<td>1-3 hours</td>
<td>Ideas from your internal meetings, your own ideas, ideas from current partners, ideas from CE TA providers and OSHII specialists</td>
<td></td>
</tr>
<tr>
<td>1.6 Develop the questions you plan to use</td>
<td>Question set</td>
<td></td>
<td>CE TA providers and OSHII specialists</td>
<td></td>
</tr>
<tr>
<td>Conduct the outreach</td>
<td>2.1 Set up, hold and record one-on-one meetings</td>
<td>3 - 4 hours for all tasks around each meeting</td>
<td>Record Sheet</td>
<td></td>
</tr>
<tr>
<td>Assess the information gathered</td>
<td>3.1 Review meeting summaries and write initial findings</td>
<td>4 hours</td>
<td>Compilation of findings with thoughts on next steps</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2 Determine in more meetings are needed (if yes, go back to 1.5 and identify more people)</td>
<td></td>
<td>May want to do this with other staff</td>
<td></td>
</tr>
<tr>
<td>Share the results with those you met with</td>
<td>4.1 Share summarized results with people who were part of the on-on-ones to confirm and expand upon your assessment</td>
<td></td>
<td>May want to do this with other staff</td>
<td></td>
</tr>
<tr>
<td>Partnership exploration</td>
<td>5.1 Begin a discussion of what new partnerships might work to advance PSE work with potential partners identified through this engagement process</td>
<td></td>
<td>May want to do this with other staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Then, develop new partnership based on information, new relationships, etc.</td>
<td></td>
<td>May want to do this with other staff</td>
<td></td>
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</tbody>
</table>
Tips for Conducting One-on-One Meetings

One-on-Ones are a community organizing tool (community organizing is people working together to achieve positive change in their community) for the purpose of establishing a relationship through conversation and sharing stories.

One-on-Ones are not a key informant interview where you might have a list of questions and you’re a neutral recorder of responses.

One-on-Ones are not “marketing” where you’re just trying to “sell” someone on the importance of your cause/group.

Instead you’re trying to find out where their interests lie, and how you might find commonality to engage them in the work creating a healthy community (it might not be attending meetings).

A Few Key Tips

When you call to make a time to meet:
- Use a personal connection
- Try to be as general as possible about the purpose of the conversation (I just want to meet to hear about your concerns about creating a healthy community)
- Meet in a place that’s comfortable for the person you’re meeting (their office/home or nearby public space)
- Have the first meeting be around 30-40 minutes
- Give them the opportunity to say “yes” to the meeting (Is it ok if I stop by then?)

At the meeting:
- Try to make a personal connection – find out how long they’ve been in the community, what they’re personally concerned about, what they’d like to see change
- Share your personal story, too (why you care about this community, how you’re involved, etc.)
- You might save the invite or “ask” until the second meeting
- Ask if there are other people you should talk to
- Make sure to tell them you’d like to call them again to continue the conversation (and give them the opportunity to say “yes”)
After the meeting:
- Jot down your thoughts about the meeting (What’s their story? Key interests/motivators?)
- Follow-up with a thank you note or call
- Arrange another meeting time if that’s what you agreed to do (or find them at a community event)

Adapted from a tool developed by the Regional Center for Healthy Communities for SHIP Grantees
One-To-One Meeting Recording Sheet

Name: _________________________________________________________
Date of meeting:  ________________________________________________
Organization (If applicable): _______________________________________
Contact information:

What does this person care most about? Why? What do they get excited talking about?

What specific concerns or ideas does this person have?

Other important things I learned about this person – their story? – their interests?

What might be potential partnerships with this person and/or their organization? Additional contacts suggested by this person.

Follow-up –

☐ Thank you note/email    ☐ Resources or materials to be sent ______________________

☐ One-to-one meetings with suggested contacts    ☐ Other ______________________
Appendix E: Advancing Health Equity Questions

Advancing Health Equity
Asking the Right Questions Is a Path to Action for Change

The central questions when looking at existing policies are:

- What are the outcomes?
- Who benefits?
- Who is left out?

The central questions to help design new policies are:

- What outcomes do we want?
- Who should be targeted to benefit?

The central questions to examining processes are:

- Who is at the decision-making table, and who is not?
- Who has the power at the table?
- Who is being held accountable and to whom or what are they accountable?

The central questions to help develop new processes are:

- How should the decision-making table be set, and who should set it?
- Who should hold decision-makers accountable, and where should this accountability take place?

The central questions to identify assumptions are:

- What values underlie the decision-making process?
- What is assumed to be true about the world and the role of the institution in the world?
- What standards of success are being applied at different decision points, and by whom?

The central questions to define new assumptions that will create the opportunity for health and healthy communities for all are:

- What are our values?
- What would it look like if equity was the starting point for decision-making?

Minnesota Department of Health
References


2 Institute of Medicine. *For the Public’s Health: Investing in a Healthier Future.*

3 Public Health Accreditation Board. PHAB Standards and Measures Version 1.0 – see Standard 5.2. Page 118.


10 Community Organizing: People Power from the Grassroots, By Dave Beckwith, with Cristina Lopez, Center for Community Change http://comm-org.wisc.edu/papers97/beckwith.htm


13x See Public Allies Web Site: http://www.publicallies.org/site/c.ikUL3PNLvF/b.2775807/k.C8B5/About_Us.htm

14 See Public Allies Web Site: http://www.publicallies.org/site/c.ikUL3PNLvF/b.2775807/k.C8B5/About_Us.htm