



BUILDING LOCAL CAPACITY TO ENGAGE HOSPITALS THROUGH COMMUNITY BENEFIT: LESSONS AND LEARNINGS FROM THREE COMMUNITIES

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EXECUTIVE SUMMARY

The Affordable Care Act (ACA) established federal benchmarks for non-profit hospital community benefit programs, including new guidelines for involving public health and engaging community members as part of routine community health needs assessments (CHNA). These guidelines and requirements create a pathway for fostering meaningful connections between hospitals and the communities they serve, and for addressing and achieving health equity at the local level.

Yet building and sustaining meaningful partnerships with hospitals to secure a “seat at the table” in community benefit conversations can be demanding work for community-based organizations confronted with a growing list of competing demands with limited resources. Hospital community benefit staff often face similar challenges.



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EXECUTIVE SUMMARY

In 2013, Community Catalyst launched a pilot project to support community-based organizations (CBOs) interested in working with local hospitals to address community health needs in three communities. The pilot focused on building community knowledge and skills for evaluating, influencing, and participating in community benefit processes through a combination of funding, technical assistance, and co-development of grassroots trainings. We sought to build community capacity to achieve concrete wins and improve hospital relationships, while testing and evaluating technical assistance approaches that would maximize CBO autonomy and effectiveness in pursuing hospital partnerships to address community residents' health priorities.

This case study summarizes findings and recommendations from key informant interviews and document reviews of Community Catalyst's work with CBOs in the Northwest Bronx, New York; Minneapolis' Phillips Neighborhood; and the Jade District in Portland, Oregon. Overwhelmingly, CBOs and residents are motivated to engage in community benefit work when presented with a cohesive framework for their lived experiences, support

“COMMUNITY INTERVIEWEES IN EACH SITE SHARED THAT NAVIGATING HOSPITAL BUREAUCRACY ADDED AN UNNECESSARY LAYER OF COMPLEXITY, REVEALING AND EXACERBATING THE POWER IMBALANCES THEY VIEWED AS INHERENT TO HOSPITAL-COMMUNITY RELATIONSHIPS— PARTICULARLY FOR COMMUNITIES AND ORGANIZATIONS SERVING PEOPLE OF COLOR.”







to follow through in engaging hospitals around concrete goals, and flexibility to choose the issues and strategies that make sense in their local contexts. Key informant interviews revealed that the grassroots trainings, which introduced the social and economic determinants of health (SDH) as a framework for understanding local health inequities, were particularly powerful for residents and professional staff. Several interviewees cited the trainings as “eye-opening,” offering residents and professional staff a way to weave multiple community issues together to build a case for health care investment in local priorities. This proved to be an effective launching pad for engaging health care institutions to support community initiatives in housing, economic development, and environmental health.

Yet fault lines in the community engagement and partnership work also emerged. For example, community interviewees in each site shared that navigating hospital bureaucracy added an unnecessary layer of complexity, revealing and exacerbating the power imbalances they viewed as inherent to hospital-community relationships—particularly for communities and organizations serving people of color. For some interviewees, these challenges were significant enough to make them question the long-term viability of their newfound partnerships.

Today, many of the services, civil rights, and basic supports that low- and moderate-income families rely on to survive are facing federal and state cuts, placing additional pressure on these residents and the organizations that serve them. Most of these cuts will fall hardest on communities of color, threatening to expand existing gaps in health outcomes and mortality rates. In this environment, robust community engagement of the residents most directly impacted by injustice and inequity is not

EXECUTIVE SUMMARY

optional. It is critical that local hospitals work directly with community-based organizations and other partners to ensure CHNAs and community benefit programs integrate and respond to the voices and vision put forward by community residents. The case study outlines the following recommendations for hospitals, advocacy partners, and funders seeking to increase and sustain CBO engagement in community benefit and broader health initiatives:

-  **Recommendation 1:** Follow the lead set by community-based organizations—particularly those led by and working with people of color.
-  **Recommendation 2:** Build staffing models and workflows that support sustained, responsive relationships with community-based partners.
-  **Recommendation 3:** Adopt funding approaches that sustain CBOs' long-term involvement to engage hospitals and other cross-sector partners around community health priorities.
-  **Recommendation 4:** Hospitals should take proactive steps to eliminate internal barriers to community engagement.
-  **Recommendation 5:** Make community benefit the starting point, not the destination, for building effective working relationships with hospitals.
-  **Recommendation 6:** Explore state and local public policy initiatives that make robust community engagement and hospital-community collaborations the easy choice.

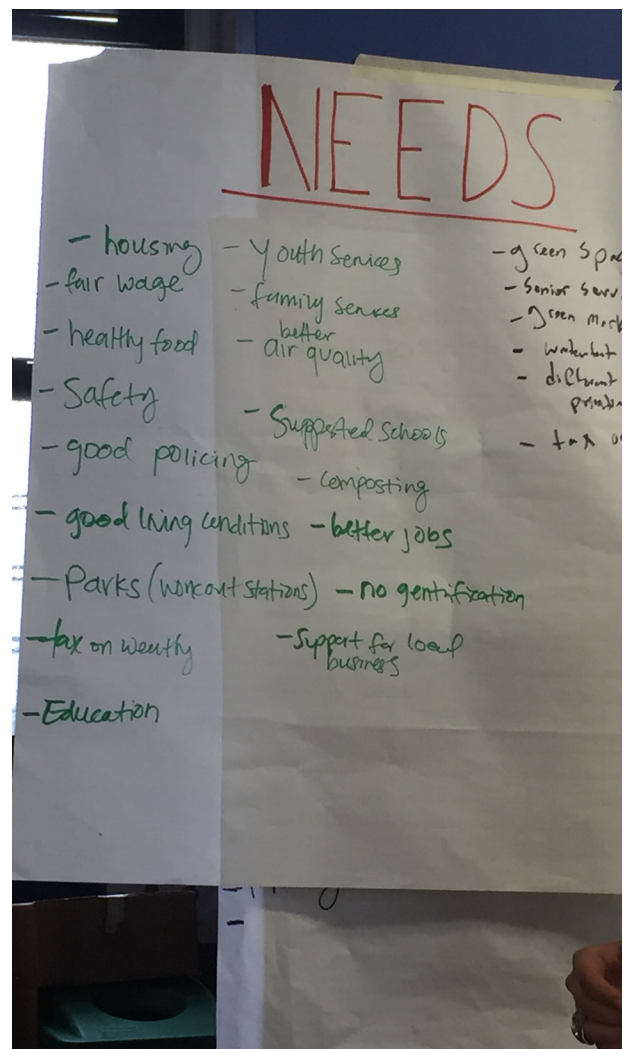
CASE STUDY REPORT

For decades, non-profit hospitals have provided services and programs to promote the health of their local communities. These “community benefit” programs, which go beyond the provision of medical care, have long presented an opportunity for hospitals to partner with community stakeholders to address a wide range of local issues, from subsidizing primary and preventive care to addressing social and economic factors, such as food security and housing, that impact health. However, for many community-based organizations, building solid working relationships with hospital staff and leadership can be a daunting challenge, even when interests align. Similarly, hospital community benefit staff interested in deepening their relationships with community partners may struggle to build and sustain relationships with multiple small organizations, or to structure engagement opportunities for community residents and organizations that reflect and honor community values, knowledge, and ways of being.

With generous support from [The Kresge Foundation](#) and the [Surdna Foundation](#), Community Catalyst launched a pilot project in 2013 to test a model for supporting community-based organizations. The purpose of this project was to proactively engage hospitals through community benefit planning processes, starting with the community health needs assessment (CHNA) now required under federal law (see sidebar, “Federal Community Benefit Requirements”). The Affordable Care Act established a process non-profit hospitals must follow to assess community health needs and implement programs to address priority issues. While the federal rules require these hospitals to “take input” from community representatives in the course of completing their CHNAs, they give hospitals great flexibility in determining how to solicit and weigh community input as they determine which community health needs to prioritize and where to invest community benefit resources.

Community Catalyst’s goal is to have communities and hospitals engage in meaningful ways that go beyond the letter of the law. For this to happen, communities and hospitals must work together to embrace the spirit of the community benefit rules. With the increased availability of publicly available reports, such as Form 990 tax filings and CHNA reports, communities can access greater information about their local hospitals. To use it effectively, they need guidance about what other hospitals are doing locally, what has happened in other communities and what they and their hospital can aspire to do collaboratively. The pilot project provided community-based organizations with financial support and technical assistance from Community Catalyst’s Hospital Accountability Project team to build deeper relationships with hospital community benefit staff and work towards addressing community health priorities.

This case study documents the findings and lessons learned



over the course of the pilot project, which operated in the Bronx, New York; Minneapolis, Minnesota; and Portland, Oregon. While the outcomes and experiences of these three communities reflect local contexts, we believe they include lessons and approaches that community-based organizations, advocacy organizations, hospitals and funders across the country can use to inform and support their own collaborations on community benefit and broad-based health initiatives.

METHODOLOGY

Community Catalyst used external consultants to gather information for this report through a combination of personal interviews and a review of project materials. Consultants conducted personal interviews with individual site leaders, key partners and participants in the three pilot communities and, in Oregon, with health care system partners working with the pilot site. They also interviewed former and current staff of Community Catalyst's Hospital Accountability Project charged with developing and implementing the pilot project. Additionally, the authors reviewed a previous internal case study that focused on the development and initial rollout of the *Social Determinants of Health 101* training with the Northwest Bronx Community and Clergy Coalition was reviewed, and findings were incorporated into this case study. Other materials referenced include Community Catalyst's internal evaluations of the *Putting People First: Working with Hospitals to Improve Community Health* training and technical assistance provided during Phase I, along with Community Catalyst staff notes from technical assistance calls with pilot sites.



KEY ELEMENTS OF PROGRAM DESIGN

To select the pilot sites, project staff first conducted an initial assessment that reviewed state and local health policy environments, previous hospital investment in community partnerships, and organizational capacity and reputation for grassroots organizing and leadership development among communities of color. In recognition of continued disparities and injustices experienced by communities of color in the United States, Hospital Accountability Project (“the Project”) staff structured the pilot to direct resources to organizations led by people of color that were working to build civic engagement and community capacity with communities of color. The pilot launched in late 2013 with three lead organizations in the following communities:

- **The Northwest Bronx, New York:** [The Northwest Bronx Community and Clergy Coalition](#) (“NWBCCC”) is a member-led, grassroots organization fighting for racial and economic justice in the Bronx, one of the most racially and ethnically diverse areas in the country. NWBCCC works to build grassroots leadership and capacity to build an inclusive Bronx and address social justice issues including educational and restorative justice, economic democracy, green jobs, housing, education, youth leadership and weatherization (weatherproofing and building modifications to decrease energy consumption).

- **The Phillips Neighborhood of Minneapolis, Minnesota:** [Waite House Community Center](#) (“Waite House”), located in South Minneapolis’ Phillips Neighborhood, works to “integrate civic engagement with human services to bring about positive change within its core focus areas of Employment and Training, Health and Nutrition, Youth Development, and Basic Needs.” Waite House is one of five community centers operated by Pillsbury United Communities. For purposes of the pilot, Waite House worked primarily with Latino residents in the Phillips Neighborhood, one of the oldest and largest neighborhoods in the city with a population that is 80 percent Latino, Native American, and African/African-American.

- **Portland, Oregon:** The [Asian Pacific American Network of Oregon](#) (“APANO”) is a statewide grassroots organization that unites Asians and Pacific Islanders to

FEDERAL COMMUNITY BENEFIT REQUIREMENTS

Under the Affordable Care Act (ACA), non-profit hospitals must now follow set guidelines to plan, implement, and evaluate their community benefit programs. Every three years, non-profit hospitals must complete a community health needs assessments (CHNA) that identifies priority community health needs, taking input from public health and community stakeholders. Findings must be made public in a CHNA report that describes:

- How the hospital defined its community for purposes of the CHNA;
- The process and methods used to collect information about community health needs;
- How community input was sought and collected;
- A prioritized list of community health needs and the process the hospital used to select priorities;
- Potential resources available to address the priority needs; and
- An evaluation of the impact of resources identified in previous CHNAs.

Hospitals must use the CHNA to inform an implementation strategy that outlines the priority health needs they will address, and what resources they will commit.

advance equity through empowering, organizing and advocating with its communities. APANO co-convenes the Oregon Health Equity Alliance (OHEA), a coalition of 25 member organizations committed to improving health and well-being through community-driven strategies. APANO is based in the Jade International District of Outer Southeast Portland, the community in focus for this work.

Project staff engaged lead partners in a series of conversations to discuss the contours of the work, both in terms of technical assistance and local site interest. Lead partners were required to commit to building a collaborative relationship with at least one local hospital's community benefit staff and to exploring the CHNA as an avenue and lever for building inroads for partnership. Each site was also required to participate in regular technical assistance calls with project staff and to test a new community benefit-focused curriculum, [Putting People First: Working with Hospitals to Improve Community Health](#). Within these parameters, lead partners had discretion to select the priority issue arising in their communities, choose which hospitals to approach, and form strategies for retaining community resident involvement and hospital engagement. This allowed lead partners to create and harness local energy that was naturally occurring around community issues.

“LEAD PARTNERS WERE REQUIRED TO COMMIT TO BUILDING A COLLABORATIVE RELATIONSHIP WITH AT LEAST ONE LOCAL HOSPITAL’S COMMUNITY BENEFIT STAFF”

Ultimately, each site participated in at least two phases of work, described below. Phase I took place during late 2013-2014 and Phase II in late 2016-early 2018. NWBCCC and Community Catalyst leveraged additional funding from the Surdna Foundation to insert a third phase in the Bronx that supported additional grassroots trainings on the social and economic determinants of health.

PHASE I—LAYING THE FOUNDATION THROUGH TRAINING AND TECHNICAL ASSISTANCE

Phase I focused heavily on building local leaders’ knowledge and comfort levels with community benefit policy; in identifying and reaching out to local hospitals to explore greater involvement in their next CHNA cycles; and in organizing initial trainings with grassroots and professional allies. The goal was to build a common level of understanding and skill among community residents and partners so that they could independently ascertain and undertake partnership opportunities with local hospitals, both during the project and independently in the future.

Early in the pilot project, each site leader was asked in a pre-survey to outline their hopes for their work with Community Catalyst. Generally, site leaders reported that they wanted community residents to clearly understand the CHNA process and how hospitals determine their community benefit spending. Site leaders sought to learn what hospitals were truly spending towards community health needs, and to compare those investments against the perceived needs in their own neighborhoods. Finally, they wanted to find ways to directly build and negotiate authentic relationships with appropriate leaders within the hospital administration.

Technical Assistance: Grounding the Work

Community Catalyst project staff provided direct technical assistance to pilot sites through bi-weekly one-on-one conference calls with lead organizations, and monthly group calls with all three pilot sites. Offering a combination of individualized and joint technical assistance ensured that each site had access to national experts who could provide intensive policy support on local community benefit issues, while also creating opportunities for sites to connect with peers across the country.

In Phase I, technical assistance provided to pilot site leaders focused heavily on fundamental policy concepts related to community benefit and the CHNA process. Project staff developed tools and approaches to help sites sift through hospital CHNA reports and community benefit information. For example, project staff created side-by-side needs comparisons that analyzed differences between the needs compiled by community organizations and what the hospital identified through the CHNA. There were some overlaps – as well as some gaps – between these lists of needs. The communities were able to use these identified overlaps and gaps in deciding which opportunities were available for hospital and community collaboration. This “desk research” helped pilot sites identify potential hospitals to approach for partnership.

As pilot site leaders conducted their own due diligence and developed a clearer understanding of potential partnership opportunities, project staff shifted technical assistance to provide strategic coaching. With the recognition that the first interaction is important for the success of the future relationship, project staff provided extensive preparation for sites’ initial meetings with hospital staff. For example, project staff conducted role-play activities between pilot participants, a former hospital CEO, and a former hospital community benefit staff person to build participants’ negotiation and relationship-building skills. This work helped sites visualize using the first contact with hospital staff to set the foundation for a meaningful relationship.

Training Curriculum and Deployment: Putting People First

A critical aspect of the technical assistance model was the incorporation of a grassroots training curriculum focused on hospital community benefit and broader concepts of community health. In Phase I, each site worked closely with project staff to develop and co-facilitate a two-day training curriculum, [Putting People First: Working with Hospitals to Improve Community Health](#). The curriculum builds knowledge of hospital community benefit and CHNAs, fosters team building through role-play activities, supports community participants to understand the data hospitals and public health leaders rely upon, and organizes community knowledge and data to inform discussions with local non-profit hospitals. It also introduces participants to the [County Health Rankings model of health](#), including an analysis of the social and economic factors that influence how long community residents live and how healthy they are while they are alive. Lead partners recruited training participants from their existing grassroots membership and coalitions; organized food, interpretation and translation services; and pre-identified a set of next steps that interested training participants could take to implement what they were learning. Working with project staff, they customized and populated the training with locally relevant data and hospital CHNA methodologies and findings.¹

HAP staff and local co-facilitators trained around 75 community residents and coalition partners in the initial *Putting People First* curriculum during Phase I. One-third of these participants received the training in Spanish through dual or simultaneous interpretation and translation of written materials.² Using tools and resources provided by project staff, site leaders and training participants reviewed the methodologies hospitals used to collect and analyze community-level data and to prioritize community health needs. Critically, lead partners skillfully

¹ These CHNAs were conducted in 2012 or 2013 depending on the hospital’s tax reporting cycle.

² Note, however, that most of the primary documents referenced in the trainings—hospital CHNA reports and public health data—were not available in languages other than English.

structured follow-up activities after each training that surveyed participants’ natural interests and helped create actionable plans for moving forward.

Phase I Impacts: Creating Energy and Action to Improve Community Engagement

For pilot site leaders and their training participants, taking a deep dive into the hospitals’ CHNA reports was galvanizing and informative. This process enabled site leaders and participants to discuss what the CHNA report had successfully captured about their communities, what they felt the CHNA report had missed, and what their role could be in bringing that information to hospital community benefit staff in the next CHNA cycle. As one interviewee noted: “Recognizing the scale of [community benefit] resources and the gap of community influence over how those resources could be utilized to support community health was eye-opening.”

In all three sites, training participants expressed interest in working with hospitals to improve their community engagement processes in the next CHNA cycle. For example, most hospitals reviewed by the pilot sites relied heavily on surveys and focus groups to reach out to community residents and organizations and populate information about community priorities. Training participants raised concerns that these methodologies did not adequately reach residents speaking languages other than English. Many saw opportunities for hospitals to work directly with smaller community-based organizations to reach residents whom they felt had been under-represented. Participants also frequently raised the desire to advocate for the inclusion of community issues—many related to social and economic health determinants—that were either not raised in? the CHNA, or were raised but not addressed as a priority in the hospital’s accompanying implementation strategy.



Following the trainings, a group from each pilot site met with the hospitals whose CHNAs they had reviewed and analyzed. While some of the pilot site partners had previously interacted with the hospitals, many had not. This outreach led directly to the following outcomes:

- NWBCCC reached out to Montefiore Medical Center community benefit staff to discuss potential partnerships to enhance community engagement in Montefiore’s next CHNA. Following multiple meetings, Montefiore pointed NWBCCC to a new funding opportunity to host Community Consultations for [Take Care NY 2020](#), the City of New York Health Department’s blueprint for health. NWBCCC applied and the Health Department selected them to convene community residents around health-related issues, including social and economic determinants, through Take Care [NY’s Neighborhood Health Initiative](#).
- Waite House cultivated new relationships with Children’s Hospital, gaining a formal seat on the hospital’s community benefit advisory board. Children’s 2016 CHNA report names asthma as a priority health issue and structural racism as a determinant of health.³ Community partners believed that this was a direct result of changing the voices at the table to uplift local priorities and perspectives about what matters for health.
- In Oregon, APANO and its partners on the Oregon Health Equity Alliance including the Urban League of Portland, the Oregon Latino Health Coalition and the Native American Youth and Family Center were able to engage more diverse voices and insert community knowledge into the Healthy Columbia Willamette Community Health Needs Assessment and Community Health Improvement Plan.

PHASE II—BUILDING PARTNERSHIPS WITH HOSPITALS TO DEEPEN COMMUNITY ENGAGEMENT AND DRIVE INVESTMENT IN COMMUNITY PRIORITIES

Despite a significant gap between phases, each pilot site was enthusiastic about continuing this pilot work in Phase II. Instead of focusing on community engagement in the formal CHNA process, organizers from each pilot site pivoted to identify a community-driven health priority and build a goal-oriented strategy for engaging local hospitals to support their approach. The priorities they identified include the following:

- Community violence and the connection to a lack of economic opportunity as a root cause (the Bronx);
- Equitable economies through workforce development (the Bronx) and development without displacement (Portland);
- Naming and addressing structural racism as a health indicator (Minneapolis);
- Environmental health (air pollution in Minneapolis and “sick buildings” in the Bronx triggering asthma);
- Housing (healthy housing in the Bronx; affordable housing in Portland); and
- Maintaining community cohesion through affordable housing and a co-located cultural center (Portland).

In all three communities, site leaders were able to leverage their community benefit knowledge and relationships to invite hospitals and other health care partners to community tables. In the Bronx, training participants’ interest had coalesced around several community health needs. As Bronx participants worked through training materials and learned about the connection between income inequality, unsafe housing, and asthma, the ideas for what became the [Bronx Healthy Buildings Program](#) began to take shape.⁴

³ <https://www.childrensmn.org/2018/01/24/75563/>

⁴ The BUILD Health Challenge, “Bronx Healthy Buildings Program” [description](#).

According to one Bronx leader: “The first idea of the Program came from the training. We learned that asthma was a key barrier to health. [We developed] a partnership [with Montefiore Medical Center] to use hospital data to find asthma hotspots to then improve building conditions.”

“ONE OF THE STRATEGIES THAT WORKED ACROSS THE WHOLE PROJECT WAS THAT SUPPORT FROM THE HOSPITALS HELPED US GENERATE MONEY FOR THE HOUSING PROJECT; AND VICE VERSA—THE FACT THAT WE HAD FUNDING FOR HOUSING WAS INSTRUMENTAL IN GETTING HOSPITAL SUPPORT.”

PORTLAND COMMUNITY PARTICIPANT

Partners no longer needed intensive trainings in the fundamentals of community benefit policy. Instead, common technical assistance requests for project staff involved gathering academic research to help pilot sites build strong arguments about the health-related impacts of certain social and economic health determinants; tracking down case studies; and crafting talking points that would resonate with hospitals and spur investment in sites’ priorities. As pilot sites’ individual projects crystallized, they relied more heavily on local partners to provide specific policy and financing expertise on issues that included community development, affordable housing and green economies.

Project staff continued to play a key background role in helping to prepare site leaders and community partners for hospital meetings through webinars, video conferencing and in-person strategy sessions. For example, instead of a full-scale *Putting People First* training, APANO and Project staff met monthly with partners to conceive and execute a single-day strategy session with partners involved in the Jade District Cultural Center capital campaign. The strategy session culminated in a

In others, site leaders were aware of pressing community needs through either their direct work with community residents or their partnerships at other community tables focused on housing, economic development, and the environment. In Portland, APANO and community partners used their knowledge of hospital community benefit processes to seek hospital investment in their ongoing [Jade District Cultural Center](#) capital campaign, which focused on raising financing and broad community support for a co-located cultural center and affordable family housing in a rapidly gentrifying city. APANO led coordination between community partners, including Rose Community Development Corporation and Portland Community College, members of the Oregon Health Equity Alliance, and other groups to make the ask of hospitals as one part of a multi-faceted fundraising campaign. In Minneapolis, Waite House facilitated relationships between Children’s Hospital and Nexus Community Partners and other partners involved in the City’s [Green Zones Initiative](#), which focuses on building community-driven solutions to address the higher rates of environmental pollutants that impact communities of color, particularly those with lower incomes.

Technical Assistance: Shifting Gears to Address Social and Economic Health Determinants

Technical assistance needs shifted and diverged considerably during Phase II as pilot sites pursued very different issues.



successful same-day meeting with multiple hospitals' community benefit staff, a coordinated care organization and regional government officials from the Portland Metro area. APANO performed significant legwork and outreach to health care, government and community partners prior to the day to pave a path for partnership, which was a critical factor in the project's overall success.

“THE CO-CREATION OF THE HEALTH DETERMINANTS CURRICULUM IS ANOTHER MILESTONE. IT IS A WAY TO TRAIN LOCAL RESIDENTS AND LEADERS SO THEY UNDERSTAND HEALTH DETERMINANTS PARTICULARLY AROUND COMMUNITY BENEFIT. THE WORK ALSO EXPANDED AN UNDERSTANDING OF WHAT HEALTH JUSTICE IS. IT PROVIDED A BROADER FRAMEWORK AND IT IS INTERTWINED WITH OTHER ISSUES (LIKE HOUSING, ECONOMIC JUSTICE, WORKFORCE DEVELOPMENT).”
NEW YORK COALITION MEMBER

Bronx site effectively comprised three phases of work due to this additional funding.

⁶Community facilitators participating in the initial train-the-trainers curriculum included Participants in that training included a New York State senator, a hospital representative, the Bronx Borough President, members of labor union SEIU 1199, representatives of the Bronx District Public Health Department, staff from the Bronx Partners for Healthy Communities, and community residents.

Training: A New Curriculum Emerges

Following Phase I, members of the NWBCCC coalition expressed a desire to develop a grassroots training that focused more explicitly on the social and economic determinants of health, and the role of health care institutions in addressing upstream community issues like poor housing quality, lack of job opportunities and violence. Momentum for this effort increased due to the synergy created through NWBCCC and Montefiore Medical Center's successful [BUILD Health Challenge grant](#) award, which was announced in June 2015. Within the context of that housing-focused effort and NWBCCC's desire to enlist community members in its action groups, the planning for Phase II in the Bronx shifted gears.

The result was a new train-the-trainer curriculum: *Social Determinants of Health 101* (“SDH 101”). The training combines components of the Putting People First training curriculum with asset mapping materials from MIT's Community Innovators Lab/[Bronx Cooperative Development Initiative](#) Economic Democracy curriculum.⁵ At the prompting of NWBCCC partners, the curriculum also incorporates elements and activities that address trauma and includes a “[Causes of the Causes](#)” root cause analysis.

Fifteen community facilitators completed the train-the-trainer *Social Determinants of Health 101* curriculum during Phase II.⁶ They subsequently hosted additional training sessions, recruiting and training over 850 Bronx residents and enlisting them to work with NWBCCC on initiatives related to hospital CHNAs, healthy housing, and health-in-all policies legislation.

Putting It into Practice: Hospital Investments in Local Health Priorities

Sites advanced their existing relationships with hospital partners in Phase II. In the Bronx, NWBCCC and Montefiore identified curbing asthma-related hospital visits as a shared area of interest.

⁵Community Catalyst leveraged local funding from the Surdna Foundation to support the development of the SDH 101 trainers' curriculum and initial trainings in the Bronx. The

Working with other partners, they successfully applied for a [BUILD Health Challenge](#) grant. The Program used hospital data to determine asthma “hot spots” in apartment buildings around the borough. Additionally, the Program addressed NWBCCC’s interests in providing economic opportunity for Bronx Residents: the coalition has been working with a local community college to create an integrated pest management-training program, with 30 residents slated to begin the training this summer.

In Portland, the APANO-led efforts to raise funding from health care institutions for the Jade District Cultural Center were successful. Community partners successfully raised the bulk of the financing needed to support the affordable housing component of the development, and completed extensive community engagement in the neighborhood to win support for the initiative. The Cultural Center was a different kind of financing lift. Following the community’s invitation to collaborate in investment, Kaiser Permanente NW, Providence Health Systems, and CareOregon coordinated with one another to commit \$140,000 towards the Cultural Center.

Progress in Minneapolis was more measured, and potentially impacted by the departure of a key ally within the hospital’s community benefit department. After Waite House facilitated new connections between the hospital and the Green Zone Initiative, the hospital proactively reached out to identify ways they could support the Green Zone work in local communities. Partners interpreted the hospital’s willingness to sit and listen to what was coming from the community as a desire to pursue a different kind of partnership. However, the staff member who had been working with the community left the hospital, and conversations about sharing data on asthma-related hospital visits with community partners never materialized.

PILOT PROGRAM IMPACTS



Two new grassroots training curricula and tools



Over **925 community residents trained**, including **15 community facilitators** through train-the-trainer module



New formal roles for MN and NY community partners in building community engagement in local community health assessment processes



Health care institutions invested in green jobs, healthy housing, and development without displacement through the Bronx Healthy Buildings Program and Jade Cultural Center Capital Campaign



An OR report points the way for state policy changes to improve community benefit investment

Lessons Learned

Community Catalyst's work with the pilot site communities provided a variety of lessons that are still relevant to other communities. Training and assisting these communities allowed project staff to move from conceptual thinking to applied work in real life settings. Staff members were able to test assumptions about what community-based organizations might need to be effective and work with them in partnership to collaboratively address real-time situations in their evolving relationships with hospitals. For community partners, the pilot project also succeeded in increasing organizational knowledge and capacity regarding community benefit and social determinants of health, and in providing concrete knowledge and skills community leaders could then bring to their conversations with health care institutions and local policymakers.

Interviewees identified the following lessons from Project staff and pilot site efforts as valuable to other advocacy organizations, funders, hospitals, and community-based groups.

A. Community-based organizations are best positioned to set the course for determining goals and strategies for engaging local hospitals, based on their needs and local context.

Project staff operated from the assumption that the lead partners' abilities to bring community residents and partners to the table directly contributed to their successful outreach to local hospitals. While Community Catalyst staff could probe and provide context, community partners were the ones with legitimate reaches into the local community, and the ones who would be holding the relationships with hospitals over the long-term. Their analysis and sense of how hospitals were making key decisions about community engagement and community benefit investment, and knowledge of other contextual factors impacting both the community and the hospital, appropriately drove their outreach strategies. Over the course of the pilot project, each site skillfully deployed the tools, information and guidance provided to recast community priorities in ways that resonated with health care partners and led to success.

The level of trust built between site partners and project staff led to a willingness to share and hear critiques that added value to the broader Project. To cite one example, NWBCCC partner Chhaya Chhoum, executive director of [Mekong NYC](#), added components to the *Social Determinants of Health 101* training that addressed trauma—including ways that the training might surface trauma for participants—while others suggested including a “[Causes of the Causes](#)” root cause analysis. These changes proved powerful for Bronx residents, adding a level of emotional depth that earlier trainings lacked. In other sites, community-based partners offered valuable feedback that helped project staff translate dense policy material for community residents and partners who came to the work without a deep knowledge base in health care policy.

“[THE PILOT PROJECT] REALLY GREW THE RELATIONSHIPS WE HAD. WE HAD WORKED ON A FEW HEALTH-RELATED PROJECTS BEFORE. BUT OUR RELATIONSHIP WITH THE HOSPITALS TOOK A QUANTUM LEAP WITH THIS PROJECT.”
PORTLAND COALITION MEMBER

A key lesson was the importance of community self-assessment and reflection before the pilot site effort. Because funding to support the pilot program was limited, it was also critical to clarify expectations about goals and technical assistance to ensure that involvement would add local capacity to pursue existing community priorities, not detract from them. This was essential for both focusing Community Catalyst's work with the community and for pilot sites to set their own priorities and goals, in the context of the sometimes-problematic relationship the local non-profit hospital had with the community. These self-assessments had the added benefit of enabling project staff to tailor tools and provide support that was directly responsive to building community knowledge of the CHNA process in Phase I, and of shifting gears to win hospital support for community initiatives addressing the social and economic health determinants in Phase II. This goal-setting process is a valid starting point for other communities.

B. Community-based organizations and residents are motivated by policy analysis and insights that help them develop concrete, actionable plans for engaging health care partners around community priorities.

The project's model for providing technical assistance supported community residents and partners to engage local hospitals in contextually appropriate, goal-oriented ways. For example, Community Catalyst's approach included leading sites in a review of the local history of interaction between the hospitals and the community, which in many cases was not positive. The result of that review, in conjunction with Community Catalyst support for understanding how the hospital conducted its CHNA process, was that each site developed a more sophisticated level of strategy and clearer objectives for community benefit engagement. The training curricula and materials helped communities to identify and challenge weaknesses in some hospital-led CHNA data collection processes (e.g. not reaching or inappropriately grouping members of vulnerable populations and not asking questions that allowed for community-identified needs). However, they also gave community participants a roadmap for approaching hospitals from a posture of collaboration to address these concerns.

Interviewees cited many elements of the technical assistance model—tools, training curricula, and one-on-one technical assistance through policy support and strategic coaching—as effective supports that changed how community partners prepared to engage hospitals. Both community and health care interviewees noted the change in approach after communities received supportive technical experience. One community leader noted:

“A lot of work went into play before we sat down with the hospitals. It was important because we were brought to terms about what [collaboration] could look like through [Community Catalyst's] work—[their] expertise was inextricably linked to our success. We were able to feel strong about what we were asking for.”

Health care institutions also noticed that pilot sites had done their homework. One Oregon health care leader stated, “It was obvious they had done significant community engagement. They did due diligence and had data linking to health outcomes and disparities.” Another shared that, “The series of meetings were well done and well communicated. [APANO] put it out there that they were looking for a health care system investment in this community initiative—that was important—for a community organization to push us to have the conversation.”

C. Grassroots trainings can bolster technical assistance offered to professional staff, creating meaningful experiences for community residents and building a ready base for further action.

The trainings acclimated participants to the language of community benefit, and presented them with a framework—through social and economic health determinants—for connecting community priorities around

pollution, violence and community safety, and equitable development to health in ways that would resonate in later work with hospitals and health care institutions. Interviewees noted that training activities shifted participants' sense of their own roles (both real and potential) in contributing to the shared work of improving community health. Stated one:

“The time we spent role playing about what aspect each community partner can bring was important. It changed our posture. We were informed and knew how to play the game that is setting expectations and asking for financial participation. It changed the way community members can do this.”

Another stated that the trainings “made me realize I need to get involved.... I began to learn ‘why do I see certain things in particular neighborhoods’ – obesity, high blood pressure. [I]t was a real eye-opener. We talked about housing, restorative justice and [how] all of that affects health.”

D. The social and economic determinants of health gave both community residents and partners a common framework they could use to strategize and discuss various threads of their work and lived experiences.

Each of the pilot sites pointed to the awareness and increased understanding around social determinants of health as the biggest shift that resulted from this project. For some participants, the learnings were personal. This was a powerful approach that helped many residents and partners see how their priority concerns, which ranged significantly from transportation to pollution to housing, connected to health outcomes and life expectancy. One Bronx community leader stated: “You could see the light bulbs going off for people at the Train the Trainer session. [It pulled] back the layers for people to understand that health issues are economic and is not a personal choice but there are ways we as a community can address them.”

Framing community priorities using the social and economic determinants of health was also useful in reaching out to cross-sector and health care partners. As one Minnesota leader stated, “Being able to see how everything connects to health—we couldn’t articulate that before. Having that health connection to the various elements of life has helped us evolve how we approach issues.” The framework also helped bridge the divide between how community participants tend to see and experience life in their communities, and how hospitals approach community benefit from a health care access and services-oriented perspective. A project staff member described it as finding common language, stating that: “Community benefit is a challenging lever. The hospitals had their language and the community had theirs. Social determinants worked to bring the two together.”

E. Hospitals have room to grow with regard to community engagement in the community benefit planning and implementation process.

Another key lesson from the pilot site work is that local hospitals do not always recognize the important resource community-based organizations represent for engaging vulnerable communities. While hospitals are required to address vulnerable communities as part of their CHNAs, our pilot site work indicated that they rarely utilize available community assets that can help them more thoroughly engage those communities. Initial interactions between the site partners and their local hospital demonstrated that the community-based organizations had deeper relationships and insights into those communities than the hospital-led CHNAs had accessed. Similarly, pilot sites’ reviews of local CHNAs found that:

- Hospitals frequently fielded surveys or held focus groups that did not reach non-English speaking populations, resulting in findings that were disproportionately weighted towards white, English-speaking residents.
- Survey instruments and focus group questions were rarely open-ended, presenting participants with a

prescribed set of “forced choices” for naming unmet health needs that did not allow the community to raise additional issues.

- In several cases, community priorities documented in the CHNA were not listed as hospital priorities and were subsequently not pursued in hospitals’ implementation strategies, raising questions for community residents about the efficacy and purpose of community engagement.
- In one community, the data compilation and analysis combined certain ethnic groups (i.e., African Americans and Africans) that residents felt had fundamentally different experiences and challenges, providing for misleading information and potentially, interventions that are not culturally competent.

Each of the pilot communities was able to parlay their knowledge of the community benefit process into improved standing and, in some cases, formal roles in hospital and public health assessment and planning processes. While these are certainly positive developments, it is worth noting that the community partners—not the hospitals—identified the gaps, initiated the outreach and formulated the asks that led to these shifts in hospital approaches. Numerous community partners pointed out that, although the law requires hospitals to gather community input for CHNAs, the community has de facto responsibility for reaching out and pushing hospitals to adopt a more intensive model of engagement.

F. Hospital bureaucracy adds to the power imbalances community-based organizations already face when navigating new hospital relationships.

Impressively, each hospital approached by pilot sites took steps to deepen their engagement with community partners. At the same time, interviewees cited challenges or, in several cases, dissatisfaction with hospital decisions in response to their requests.

The first common challenge community partners cited was the difficulty they faced in determining where to invest their time and social capital building hospital relationships. While sites generally did not have difficulty contacting community benefit staff, they noted that these staff do not always hold decision-making power, particularly over financial resources. Hospitals’ internal processes for grant-making and strategic investments differ considerably and can be opaque to outsiders. They cited hospitals’ insularity as a barrier to mapping internal stakeholders to know who makes decisions and what processes are important to influence or track.

In some cases, pilot site leaders built solid working relationships with hospital staff who were not decision-makers. While the conversations created understanding between the hospital staff and the community participants, they did not always offer the opportunity to take the partnership to the next level. Some interviewees expressed frustration when original discussions about collaboration with community benefit staff fell through: “Historical barriers and the actual bureaucracy to build relationships with someone at a hospital is not easy. The whole situation with [backtracking] and then stalling adds to the historic distrust of hospitals.”

Hospital staffing changes also posed a particular problem. As staff left or moved on to other roles, it created uncertainty for community partners who had been cultivating relationships with individuals over several years. One interviewee noted, “You would find champions, and then they’d leave.” Another site leader observed, “When the person essential to this process [within the hospital] got laid off, we lost someone critical to transforming the system.”

Finally, several interviewees noted that hospitals generally expected the community-based organizations to conform to hospital timelines, structures, and definitions of success. Some noted that the outcomes-driven language and culture in which hospitals are used to operating places an extremely high bar on community-based work. Residents and community partners in some sites were frustrated by how long it took to set up initial

meetings with hospital staff, or by what they perceived as redirection by hospital staff towards issues and processes that were not at the core of the community group's original interest but instead met a hospital priority. Community interviewees expressed this as hospitals "shifting the risk" of the engagement onto community partners. One interviewee stated, "Savvy hospital leaders are most often holding onto what the hospital wants and needs first and foremost."

While these approaches may be more comfortable for hospitals in the short term, they may make future community engagement efforts more challenging. Several interviewees noted that it can be difficult for community-based organizations to continue bringing residents and partners to the table if community members never see an outcome that responds to their actual desires and priorities, or if it seems that the relationship between the two entities is not progressing. In at least one site, community partners ended the pilot project asking active questions about where they should "go along to get ahead" with the hospital's priorities, versus abandoning the collaboration to make more of a push for their own.

G. Funder flexibility can support community innovation and learning.

The pilot project focused on building community-based organizations' capacity to define, and pursue, their own goals for partnerships with local hospitals regarding community health priorities. The pilot project's funders were both open to what the community needed, which allowed lead partners to be directly responsive to their communities, instead of to a funder mandate. It also permitted project staff to adopt a more responsive, hands-off approach so that site leaders could find ways to make the project fit into and meet the needs of their community.



Recommendations for Success

This pilot project explored what is possible when strong, effective community-based organizations are well-versed in the language and theory of community benefit, and skilled at building action-oriented relationships with community residents and hospital community benefit staff. The project demonstrated that, given knowledge and actionable tools, community organizations have the power to build relationships, identify community needs and represent their community's interests. In all three pilot sites, the increased understanding about the community benefit process and strategic engagement earned each partner more visibility and consideration from health care and public health partners than they had prior to their involvement and resulted in tangible wins.

But today, communities—particularly communities of color—face even more of an uphill walk than they did during the pilot. Both hospitals and community partners are wrestling with the impact of the changing political environment around social supports and health care. Major changes in Medicaid, housing and food assistance programs have either already occurred or are currently being proposed in Washington and in state capitals. These changes run the risk of further eroding the local safety net many communities rely on to make ends meet. Shifts in the political winds may result in some cautiousness on the part of hospitals and health care institutions about future investments in “upstream” health issues that are still outside hospitals’ core book of business—just as community-based organizations need more support than ever.

If vulnerable communities are to weather the coming storms, large anchor institutions—like hospitals—and smaller community-based organizations will need to find new ways of working together. For funders, advocates, and health care institutions seeking to invest in and amplify community-based initiatives, these recommendations, based on the pilot site experience, may make success more likely.

Recommendation 1: Follow the lead set by community-based organizations—particularly those led by and working with people of color.

Community-based organizations working with communities of color, immigrant communities and others experiencing health inequities, do not have the luxury of overlooking pressing community issues. Making collaborations with community-based organizations meaningful for them—not just for health care partners—requires organizing work around the expertise and direction set by community organizations and residents. As one Minnesota leader noted, many members of these communities are in survival mode. Larger organizations may bring theories of change or policy goals that do not acknowledge or integrate a community's history, or how the fight for daily survival changes the way work happens and is perceived. Because community-based organizations and residents are “living the issues,” every action they take to influence policy or institutional practice is a balance of personal history, power, and political context. The pilot sites demonstrated the value of providing community-based organizations with a framework and context for decision-making, and supporting them to set strategy and direction.

Recommendation 2: Build staffing models and workflows that support sustained, responsive relationships with community-based partners.

Project staff set aside significant time to focus exclusively on building relationships with local leaders, joining

evening and weekend meetings on the phone and traveling to each site in person, to cement their understanding of the communities' dreams and concerns, and develop trust. While similar levels of effort may not be possible in every community, organizations should plan to make an upfront investment in community-based partnerships that requires intentional time upfront, based around the community's calendar. Working in multi-person teams can assist in creating continuity when staff move on. Additionally, advocacy partners and health care institutions should commit to hiring bilingual staff and/or supporting community-based organizations financially to bring in translators and interpreters who can lead meetings in participants' primary languages.

Recommendation 3: Local funders should adopt approaches that sustain long-term involvement by community-based organizations to engage hospitals and other cross-sector partners around community health priorities.

For the pilot sites, having resources to bring together natural stakeholders who lacked time and money to meet made a difference and provided an advantage they lacked earlier in their work. Yet every pilot site noted the challenge of finding funding to support the staff time and commitment needed to take on building hospital partnerships over the long term. Community organizations have to dedicate resources to ongoing intensive community training and long-term relationship building work with hospitals to be successful. One leader noted, “We [already] struggle with communities of color having stable staff who have long tenure and continuity. Funding is not sustained, turnover is high and it makes it a struggle to keep ongoing capacity.”

Moving forward, local funders—including health care institutions—should fund community-based organizations at levels that allow their participation in CHNAs. Additionally, community health processes should be integrated into the fabric of the organization, not solely as a campaign or periodic activities. Sustained funding allows them to hire staff and take the time required to build community knowledge, civic engagement skills and the necessary hospital relationships. This includes providing funding for local and state-based technical assistance partners—including local partners from sectors like health care, housing, community development, environmental health, education, and others—who can help lead partners find data, frame issues, and develop goals on social and economic priorities that will resonate with hospitals.

Recommendation 4: Hospitals should take proactive steps to eliminate internal barriers to community engagement.

Hospitals and community-based organizations are more likely to succeed in building partnerships when they make good faith efforts to understand and accommodate the different pressures and organizational cultures in which the other operates. At the same time, interviewees acknowledged that the current burden for adjusting to cultural norms falls too heavily on community-based partners, and can crush burgeoning partnerships and community-led initiatives in their infancy.

To rebalance this dynamic, hospitals need to allow their staff room to build connections and be willing to bend their “usual” way of doing business. Hospitals can provide community benefit staff with flexibility and resources to build and sustain multiple community partnerships—including by increasing staffing FTEs in their community benefit and community health departments. At the same time, hospitals should consider ways to make community engagement a greater part of the hospital's institutional values and culture, so that community organizations have more than one point of contact when staff move on to other work. This could include increasing transparency about hospital decision-making and community benefit investments. Ultimately, hospitals that wish to achieve

effective and ongoing community engagement must take steps to ensure the engagement is of value to the community partners—and be willing to define success from the community’s point of view, not just the hospital’s.

Recommendation 5: Make community benefit the starting point, not the destination, for building effective working relationships with hospitals.

When the pilot project began, most lead partners cited a desire to understand how hospitals were investing community benefit resources. By the end, sites were confident in the assets they individually brought to the table. They frequently expressed a bigger vision for how local hospitals could invest in community efforts that outstripped the community benefit requirements, through supply chain, delivery system reform, environmental protections, and joint advocacy on community priorities related to food, air quality, immigration and housing. Community benefit was just one component of the larger conversation.

Community-based organizations that can pivot to frame a compelling local issue, show that they are organized and have trust in the communities they represent, and identify areas of overlapping interest with the hospital, may be more successful in building long-term hospital partnerships than those that focus solely on improving the community benefit process or driving up investment. However, this work will require good-faith relationships and hospital commitment to respond to the needs of community residents who are in the eye of the storm. Whether hospitals will be open to sustaining these deeper engagements is another question.

Recommendation 6: Explore state and local public policy initiatives that make robust community engagement and hospital-community collaborations the easy choice.

The community engagement requirements found in the ACA and subsequent rulemaking were pivotal in opening the door for community-hospital dialogues and partnership around pressing needs. At the same time, pilot sites experienced hurdles and delays in their pursuits of partnerships that added value to their work and resulted in “wins” for their communities. As one leader noted:

“The hospital industry is insular with no internal leadership that creates space for meaningful community engagement. [We] have to deal with internalized racism, sexism, etc. There’s a power imbalance. How do we compete or make the case or create the sense of urgency that these conversations are critical and have to happen?”

Public policy initiatives at the state and local level can provide additional motivation for robust community engagement, open the door for further investment by health care institutions in social and economic determinants, or use other modalities of health care policy—delivery system reform, public health planning and market regulation—to drive private and public resources towards community-identified health priorities. Achieving health justice may require policymakers to intervene to ensure health care institutions are targeting resources—including, but not limited to community benefit—towards communities experiencing the brunt of inequities, including historic and current experiences of racism, sexism, and other forms of injustice.

Appendixes A, B and C follow

Appendix A: Building Hospital Relationships to Advance Affordable Housing and Cultural Cohesion in Portland, Oregon

In Portland, Oregon, the Asian Pacific American Network of Oregon (APANO) and other member organizations of the Oregon Health Equity Alliance (OHEA) coalition have developed local expertise and knowledge about community benefit, strengthened relationships with health plans and providers, and secured health care investments in local initiatives focused on preserving affordable housing and cultural cohesion in the face of gentrification.

Project Description

In 2013, APANO recruited 30 fellow members of the OHEA coalition to participate in Community Catalyst’s [Putting People First: Working with Hospitals to Improve Community Health](#) pilot training. The training focused on building the coalition’s capacity and knowledge around the hospital community benefit process and the social determinants of health by walking participants through community benefit requirements and common practices. Participants from over 20 organizations in OHEA’s network – including professional staff and community health workers – gained skills and analytic tools to evaluate local hospitals’ community benefit reports and plans in order to identify areas of shared interest and potential growth. Several participants channeled this heightened enthusiasm into later work with the Healthy Columbia Willamette Community Health Improvement Plan, a county-based community health improvement project.

By the time Community Catalyst approached APANO with a second funding opportunity in 2015, a new community priority had emerged in the the Portland neighborhood APANO had long called home, the Jade District. Here, community residents, organizers and county leadership sought to stimulate economic growth in an underserved community while creating affordable family housing units and a much-desired cultural center. APANO had already begun extensive community conversations around the project and convened a multi-sector table of community partners, including the Rose Community Development Corporation and Portland Community College. Community Catalyst worked with APANO to bring this community table up to speed on community benefit and local health care partners’ interests in addressing social and economic health determinants. Together, the partners successfully made the case for local health care investment in the [Roots to Rise Capital Campaign](#), framing the connection between health, housing and cultural cohesion. By the end of the project, three health care partners – nonprofit hospital systems, Kaiser Permanente NorthWest and Providence Health Systems – along with CareOregon, jointly committed \$140,000 in financial support for Roots to Rise.

What Other Communities Should Know

Project participants shared the following key insights for other community organizations interested in working with health care entities on social determinants of health.

- **Having a concrete goal is critical.** The Roots to Rise campaign gave community and health care partners a tangible capital-raising goal. This created a timeline and positive pressure to “learn...as we go” in a way that organically strengthened the relationships organizations already had with one another.
- **Addressing upstream social determinants of health can bring new partners to the table.** For most community partners, working with health care partners on economic development and housing issues was

new. APANO, the OHEA coalition and their community partners worked hard to frame the community's interests and connect their project to the health care partners' priorities. For their part, health care respondents found the process to be unique and engaging, reporting that it sparked interest in working with these organizations in the future.

- **Having deep knowledge of community needs and goals – and being able to “translate” those into the language and health priorities of health care partners – is key when developing and presenting partnership requests to hospitals and plans.** In Portland, each community partner had deep roots and knowledge of community needs. They could “walk the walk” of community building and organizing. By building a knowledge base around community benefit and the connections between health and social or economic issues, community leaders could also “talk the talk” with health care partners. This made it easier for everyone to connect the dots between health care partners' interests and the community's goals.
- **Funding limitations and health care bureaucracy pose real challenges to lasting partnerships.** Community partners noted that insufficient funding streams make it difficult for organizations serving communities of color to keep stable staffing with long tenures and continuity in the community. This impacts abilities to build and sustain relationships. Others noted that accommodating the fiscal calendars of the hospital systems was an unanticipated challenge, and something community groups should be mindful of when seeking financial support from hospitals for local projects.
- **Local experiences can inform state policy goals.** APANO and the OHEA coalition collaborated with SEIU Local 49, a health care union, on [Hospital Community Benefits in Oregon: Our Hospital, Our Benefit?](#) The report evaluated Oregon's current benchmarks and trends in hospital community benefit spending and called for state lawmakers to increase transparency and accountability with community benefit funds. State lawmakers introduced [HB 2115](#), which tackled some of these points, in the 2017 regular session.

IMPACTS



Over 30 partners from 20 organizations gained new knowledge and skills



Community partners increased influence in their county's health planning process



\$140,000 joint investment in community-supported mixed-use affordable housing development from three health care partners



Community and labor advocates collaborated to improve transparency in community benefit

Appendix B: Building Community Power in the Northwest Bronx: Community Residents Lead the Way on Green Jobs and Healthy Housing

In the Bronx borough of New York City, the [Northwest Bronx Community and Clergy Coalition](#) (“the Coalition”) has piloted and expanded grassroots-driven leadership approaches for community residents and organizations seeking to build positive relationships with local hospitals to address the social and economic determinants of health. The Coalition’s efforts led to a partnership with Montefiore Medical Center and other community partners around the [Bronx Healthy Buildings Program](#), an initiative that seeks to remediate housing-related asthma triggers and increase local employment opportunities.

Project Description

The Coalition and the [Bronx Cooperative Development Initiative](#) (BCDI) shared an early interest in finding ways to link economic opportunity and health for residents. In early 2014, the Coalition recruited approximately 20 partners and Bronx residents to participate in Community Catalyst’s [Putting People First: Working with Hospitals to Improve Community Health](#) pilot training. As residents and members learned more about the close connections between housing and health, an idea was born: what if hospitals and other Bronx institutions worked together to jointly address poor-quality housing, expand local job opportunities and improve health for local residents in the process?

Coalition organizers and residents decided to approach Montefiore Medical Center to identify areas of shared interest, based on the hospital’s previous community health needs assessment (CHNA), and built a strategy for engaging Montefiore’s community benefit staff to share their ideas. Over time, the Coalition and Montefiore – along with other community partners – secured funding for the [Bronx Healthy Buildings Program](#) from the BUILD Health Challenge, a consortium of national and state funders. This comprehensive program addresses asthma triggers in privately-owned apartments. This year, it will also launch job training for up to 30 residents in environmentally-friendly integrated pest management, meeting community goals to provide residents with steady employment.

What Other Communities Should Know

Through participation in the pilot, Coalition members and resident leaders gained understanding of community benefit practices and pursued several active collaborations with local hospitals to address the root causes of poor health. While not all of the ideas they proposed for partnership came to fruition, leaders and organizers shared that the pilot had helped “connect the dots” between longstanding economic and social policies, racism and inequality, and their own health and experiences in the Bronx. They highlighted the following for other grassroots groups interested in working with health care institutions:

- **Root causes resonate with community residents.** After the initial training series, Coalition partners realized residents were hungry for deeper trainings on the social and economic determinants of health. Community Catalyst, the Coalition, and BCDI co-developed a train-the-trainers curriculum that incorporated and acknowledged the social trauma in communities facing longstanding injustice, and introduced explicit frameworks around restorative justice. Between 2015-2017, the Coalition trained

15 residents and leaders to become community facilitators in the new curriculum. Subsequently, these facilitators recruited and trained over 850 community members to deploy their newfound knowledge and skills to work on hospital community benefit, housing, and health-in-all-policies issues.

- **Build expectations around the time it can take to navigate a complex hospital bureaucracy and culture.** Several grassroots leaders noted the challenges they faced in understanding and navigating hospital staff roles, responsibilities and decision-making authority. They also stressed that grassroots leaders and organizations needed to make a significant upfront investment of time to build relationships with key hospital decision-makers. Other groups may need to consider whether residents and partners have the requisite energy and capacity to sustain a long-term relational investment in the face of competing demands and local crises.
- **Prepare to navigate the tension between “partnerships and protesting.”** As one community partner noted, collaborating with health care providers may force challenging conversations, both internally and with other community partners, about the competing roles of collaboration and protest to effect change and build community power.
- **Networking is powerful; be ready to pivot.** Initial conversations between the Coalition and Montefiore revolved around the Coalition’s ideas for making the CHNA process more inclusive of non-English speakers and people without internet access. Knowing of the Coalition’s interest in robust community engagement processes, Montefiore alerted the Coalition to a funding opportunity through [Take Care NY 2020’s Neighborhood Health Initiative](#), a signature effort led by New York City’s public health department. The Coalition applied, was selected, and implemented their model for participatory community health planning as part of the citywide effort to eliminate health disparities and inequity.

IMPACTS



Fifteen community facilitators were trained to deliver the “Social Determinants of Health 101” curriculum to over 850 Bronx residents



Closer collaboration with local hospital led to BUILD Health Challenge award for the Bronx Healthy Buildings Program, including a green jobs training program for up to 30 Bronx residents



Successful application and implementation of a robust community engagement process through Take Care NY 2020

Appendix C: Building Strong Community-Hospital Partnerships to Address Structural Racism and Environmental Health in Minneapolis, MN

In Minneapolis, the [Waite House Community Center](#) built health advocacy into its existing grassroots leadership development programs for immigrants. Waite House and other community partners also strengthened collaborations with [Children’s Minnesota](#), culminating in a community health needs assessment (CHNA) process that raised and addressed community conditions as health-related concerns, and that laid the groundwork for future partnerships on environmental health.

About the Project

In 2014, Waite House worked closely with Community Catalyst staff to integrate the [Putting People First: Working with Hospitals to Improve Community Health training curriculum](#) into a larger series of grassroots leadership development trainings focused on building local residents’ capacity for civic engagement and collective leadership. Approximately 25 Latino residents of the Phillips Neighborhood completed the training in this first round, which focused on building community awareness, knowledge and skills to engage local non-profit hospitals in community benefit planning around local health priorities. The training was repeated in 2017 with a new grassroots cohort of residents.

Concurrently, Waite House’s executive director developed a strong working relationship with the community benefit staff at Children’s Minnesota, a pediatric health system serving Minneapolis, that eventually led to his serving as a member of the hospital’s Community Advisory Committee (CAC). In an effort to increase community engagement, Children’s staff gave the CAC a significant role in guiding the 2016 community health needs assessment (CHNA) process and developing criteria for prioritizing the health issues that arose from community interviews and other data. This included a decision to broaden the health topics considered in the CHNA to include “community conditions and other factors that contribute to health, such as poverty, education and housing.”¹ The [resulting CHNA](#) report named structural racism as a priority social determinant of health, and asthma as a priority health issue. For Waite House and their community partners, this was a meaningful acknowledgement of the heavier burden faced by the residents they serve. This work also built a foundation for bridging the hospital’s work with a community-based environmental initiative involving Nexus Community Partners and the Green Zone Initiative around the hospital’s potential role in reducing environmental factors that contributed to childhood asthma.

What Other Communities Should Know

The pilot project gave Waite House leadership some new language and fresh theories for understanding the issues facing the community they served, and introduced new tools to engage hospitals. Critical lessons from this site include the following:

- **It’s okay to wait for the right dance partner.** Waite House initially approached a different local hospital as a potential partner based on its shared interests in the priority health issues raised in that hospital’s CHNA report. But after several discussions, it became clear there was a mismatch between the hospital’s and Waite House’s visions for what a partnership could look like – particularly around engaging communities in the Phillips Neighborhood. By contrast, Children’s Minnesota had been talking separately with [Nexus Community Partners](#) and their [Community](#)

¹ See Ferris, M., and Rojas-Jahn, K. [Children’s Minnesota Community Health Needs Assessment](#) (December 2016), p. 8.

[Engagement Institute](#) to identify ways the hospital could support community engagement. The hospital’s interest in expanding community engagement opportunities – and their commitment to following through – clearly showed. Project participants noted that having internal champions for community engagement at Children’s and an open door for community partners made a meaningful difference, both in terms of their experience of having agency through the process and in the resulting CHNA.

- **Hospital community benefit staff play a pivotal role in establishing community connections.** The community’s perception that Children’s Hospital was willing to learn from the community – and to let the community lead – carried over into later conversations the hospital joined in with community stakeholders involved in the City’s [Green Zones Initiative](#). One participant stated, “[The hospital] wanted to learn from us. [The community benefit staff member] as a hospital representative exhibited trust and respect for community partners. People saw that there was interest and willingness to partner with the community differently.” Conversely, the later departure of this community benefit staff member created uncertainty for community partners in terms of next steps – something participants also cited as a key hazard in work that is fundamentally about building relationships.
- **Offer trainings that are culturally and linguistically responsive to the local community.** During the first training, local translators provided simultaneous Spanish translation to accommodate Community Catalyst’s English-speaking facilitators, who sought to test the training. All parties agreed that this approach was not ideal. When Waite House repeated the training in 2017, they worked with Pancho Argüelles Paz y Puente, a well-regarded immigrant-rights leader, trainer and educator, to integrate the training in Spanish and to intentionally center the health and hospital-related issues against the social, cultural, and economic policies that have worked to marginalize and oppress immigrant communities. This allowed participants to be fully comfortable and immerse themselves in the experience.
- **Building hospital partnerships with small community-based organizations – particularly those working with immigrant and other marginalized communities – requires hospitals to adopt a new model of engagement.** Multiple participants discussed the need for hospitals, as institutions, to be open to changing how they engage small community-based organizations. For some, this may include acknowledging the historic barriers to partnership that small organizations face and taking internal steps to ease bureaucratic hurdles. For others, it may require understanding and appealing to the *community’s* self-interest and specific history. Participants noted that many communities – including immigrant communities – are in survival mode every day. While they acknowledged that hospital staff can feel internal pressure to focus on short-term or “easy” wins, they encouraged hospitals to take the time to understand the history and culture of the people whose health they are trying to impact and to be willing to address root cause issues. Failing to know and acknowledge community history and daily realities will limit the effectiveness of the partnership – and of hospital efforts to address community health.

IMPACTS



Approximately 40 grassroots residents trained



Meaningful role in hospital CHNA structure and process



CHNA report addressing community priorities, including structural racism