Meeting Summary

Building Community Capacity to Prevent Flu through Faith-Based Collaboration
Aug. 12-13, 2013

INTRODUCTION
The goal of a public health and faith-based organization (FBO) partnership is to leverage public health dollars to serve hard-to-reach populations. This meeting aimed to present tools to assist in building and mobilizing partnerships that reach vulnerable, at-risk, hard-to-reach, and minority populations with needed influenza prevention and other essential public health promotion services. The information discussed is a set of model practices derived from an assessment of four years of successful work implemented in 10 different faith and community-based partnerships. It provides practice-based evidence of how partnering with FBOs makes sense to reach vulnerable and at risk minority populations. The toolkit includes:
1. The rationale and background support for health and faith-based partnerships.
2. The model practices.
3. Examples of successful faith-health partnerships.

PLENARY SESSION 1: RATIONALE FOR PUBLIC HEALTH & FAITH-BASED ORGANIZATION PARTNERSHIPS
Background
The Interfaith Health Program (IHP) at Emory University was founded as an avenue to address health disparities by bringing the resources of faith communities into the discussion. It arose from the recognition that religious organizations were some of the most pervasive and powerful institutions in almost all communities, and public health professionals, scholars, and faith communities could do more to forge collaborative relationships to share their unique perspectives and skill sets to improve communities’ health and wellness. IHP continues to encourage new thought and nurture the next generation of leaders through its four programmatic areas: Faith Health Consortium, Institute for Public Health and Faith Collaboration, Strong Partners, and Applied Research and Community Based Programming. Faith-based organizations are eligible to participate in publically funded and administered social service programs to the same degree as any other group. However, to protect the separation of church and state, there are certain restrictions on FBOs that accept government funding.1
- They may not use direct government funds to support inherently religious activities such as prayer, worship, or religious instruction.
- Organizations’ inherently religious activities must be offered separately in time or location from services that receive federal assistance.
- FBOs cannot discriminate on the basis of religion when providing services.

Rationale for Partnerships
The most salient cultural factors supporting faith-health partnerships to serve hard to reach populations are:
1. Religious institutions are pervasive social structures in communities.
2. Religious institutions hold community members’ trust.

---

3) Religious institutions have values and commitments that can align and contribute to public health goals.

There is also significant scientific evidence supporting the development of these partnerships. The social determinants of health include community environments, and as Anderson et al, present in their journal article “The Community Guide’s Model for Linking the Social Environment to Health,” religious institutions can contribute to community capital and social capital and increase resilience. The Institute of Medicine also staunchly supports improving public health infrastructure through investments in partnership building capacities. CDC’s REACH U.S. project also identified key principles to reduce health disparities in racial and ethnic minority communities including trust, community investment and expertise, trusted organizations, and community leaders, all elements frequently found in FBOs. The theoretical support of partnerships as a driver of positive outcomes includes the partnership synergy framework and the Community Coalition Action Theory, which shows significant positive outcomes, related to community partnerships to access hard-to-reach populations and effectively utilize resources.

Minnesota Department of Health’s Office of Minority and Multicultural Health
The importance of partnering with FBOs to serve hard-to-reach populations is evident in the work of Minnesota’s Office of Minority and Multicultural Health (OMMH). The goal of OMMH is to strengthen the Minnesota Department of Health by taking action to eliminate Minnesota’s health disparities and achieve health equity. This is achieved through activities such as meetings, webinars, working with content experts and consultants, producing reports, and special projects such as Infant Mortality Reviews and the Health Insurance Exchange. For many communities, especially communities of color, partnering with FBOs or having a faith-based slant is an aspect of cultural background, complementary to western medicine and epidemiology.

OMMH’s Eliminating Health Disparities Initiative (EDHI) appropriates $5.2 million annually to eliminate or reduce the health disparities in populations of color and American Indians and provides grants to multiple faith-health partnerships. One such partnership is EDHI’s Minnesota Immunization Networking Initiative, which aims to improve vaccination coverage in hard to reach populations. The program provided influenza vaccination primarily to uninsured and minority populations in the twin cities area by delivering vaccinations in non-traditional, culturally relevant, and easy to access locations.

PLENARY SESSION 2: THE MODEL PRACTICE FRAMEWORK

Background
From 2001 to 2007 CDC, in partnership with IHP, trained 78 teams of religious and public health leaders in 24 states to collaborate on eliminating health disparities. When H1N1 hit the United States in 2009, IHP and CDC identified 10 of these teams, in sites where partnerships were strong enough to jump in with community resources, to begin work aimed at vulnerable populations. The selected sites included a

---

3 Institute of Medicine (IOM) – Public Health Mission-Critical Capacity Development 2012
diverse group of FBOs. About half were faith-based health systems whose commitment to the faith-based mission translated into community outreach, but each brought a slightly different approach to outreach based on local needs and their organizations’ capabilities. Many people assume that FBOs are only places of worship with congregations, but a variety of other types of organizations with origins in a faith or with a faith-driven mission are interested in providing outreach programs.

**Site Accomplishments**

The first several years of CDC-IHP FBO partnership efforts were aimed at “evaluating what works,” and partnership accomplishments were measured by capacity building, education and vaccinations for those with limited access, and developing innovations. The quantitative evaluation of reach measured numbers of people vaccinated and educational encounters.

In 2012-2013, the evaluation shifted to more concentrated efforts to describe what works through more qualitative examinations. The evaluations looked more closely at priority populations and on developing a model practice framework.

### IMPACT

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaccination Reach</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(in persons vaccinated)</td>
<td>78,708</td>
<td>13,686</td>
<td>15,103</td>
<td>16,381</td>
</tr>
<tr>
<td></td>
<td>138 events</td>
<td>108 events</td>
<td>227 events</td>
<td></td>
</tr>
<tr>
<td><strong>Educational Encounters</strong></td>
<td>417,218</td>
<td>&gt; 4710</td>
<td>9,570</td>
<td>Not counted across sites this year</td>
</tr>
</tbody>
</table>

**Methodology**

The Model Practice Framework was developed through a practice-based discovery process using a modified Delphi technique to synthesize distinctive elements from across the 10 sites. This multi-stage evaluation took the form of document review and thematic analysis, in-person inductive identification of key elements of practice, survey to validate key elements, and group work to develop definitions and operational characteristics.

There were three phases to the model development:

- **Phase I:** Through qualitative document analysis and review, Emory staff and site representatives identified preliminary dimensions describing the work.
- **Phase II:** Through a 1.5 day iterative prioritization of the key elements, four site representatives and theoretical and public health science experts developed the first draft of the model with 25 elements.
- **Phase III:** Model validation through a survey of all 10 sites, a two-day meeting, graphical representation, and consensus review with site community leaders and national partners produced the Final Model.
The model is made up of 14 essential elements, which can be broken down to three main functions. Four Core Drivers: The Core Drivers are the fundamental elements that not only define the central elements of the partnership, they are dynamic forces in the development and implementation of a successful partnership.

- **Faith Mission as Core driver**
  - The central force that drives the organization is grounded in beliefs and principles that sustain energy, motivation, and commitment to serving the collective good.

- **Inclusivity**
  - The intentional practice of honoring different beliefs, values, and worldviews when acting as translator, broker, advocate, and co-learner.

- **Compassion-Driven Flexibility**
  - This arises from the commitment to adapt and serve the community as needed through creativity and compassion.

- **Trust in Community**
  - More than just using the word empowerment, this is a shared investment with the community.
Meeting Summary

Five Processes: Faith-health partnerships have unique elements that make them strong, and it is the day-to-day processes that keep them alive.

- **Marry Stories with Data**
  - The human narrative is important in faith communities, so combining data and stories about human lives that were impacted communicates and contextualizes the work for all partners.

- **Relationships and Presence as Paramount**
  - Give diligent and visible attention to relationship-building with communities and partners by giving time, being present, listening, and sharing power.

- **Build and Maintain Trust**
  - Trust is primarily relational and is built over time when respect for differences, commitment to the good of the community, integrity, and transparency are experienced consistently in challenging collaborative endeavors.

- **Collaboration that Endures**
  - Build partnership relationships that over time address a breadth of holistic health interests with an intersecting depth of long-term commitment to making a difference together.

- **Identify Trusted Leaders**
  - Identify and make connections to leaders who share commitments, can articulate a common mission, represent different voices and parts of the community, contribute to the deep bench of trust, and support each other in getting the work done.

Five Infrastructure Capacities: These are the capacities and structures necessary for strong and effective partnerships

- **Leadership Anchors the Work**
  - A individual or organization with an enduring commitment to the larger faith mission must take or share the primary role in sustaining and supporting the collective work of partners.

- **Volunteers as Groundwork**
  - Volunteers are often the workforce of these efforts adding relational and response capacity and service flexibility. They give because they care and want to serve and make a difference. As much as they care, they must be cared for and helped to see their impact.

- **Circle of Core Partners**
  - There is a core group of leaders and organizations that have a shared interest and recognize the long term benefit of their collaboration. They are willing to make institutional commitments that serve larger community needs and can sustain the engagement of an extended network of partners and stakeholders when needed.

- **External Networks**
  - When doing community-level and faith-based work, it is important to be adept at initiating and give time to maintaining connectivity to external networks of organizations and leaders for resources, support, and staying relevant.
Meeting Summary

- Multi-Sectoral Collaboration
  - Foster collaborative relationships and engage diverse groups in order for a wide variety of resources and commitments to be brought to bear on community health and well-being.

Case Example

Compassion Driven Flexibility:
In order to address the needs of hard-to-reach populations, Los Angeles-area organization Tzu Chi maintains flexibility to work when and wherever people are best served. This always involves mobilizing large numbers of volunteers and includes setting up clinics near homeless shelters during peak entrance hours or near migrant farmworker work sites before and after work hours.

During the fall of 2011, Tzu Chi worked with the San Gabriel Valley Homeless Consortium to provide flu clinic services at winter shelter sites from 7-10 p.m. twice weekly. They had a total of 30 medical and dental events at six church shelter sites. Because of this commitment to be where they could address the needs of hard-to-reach populations, they were able to vaccinate people like a 46-year-old disabled homeless man. Although he had disability medical insurance, his lack of a means of transportation made it virtually impossible for him to get regular flu shots. Flu clinic services at winter shelter sites made it easier for him and many others to receive this important service.

What Does it Take?
- Tzu Chi makes a point to be a part of community response planning endeavors and to stay connected through public health learning networks.
- The public health department recognizes them as an important part of the “public health system” and includes them in preparedness planning processes and community outreach activity coordination.
- Tzu Chi has standards and policies that translate into well-trained, trusted volunteers. They work with the health department and others to assure this.
- Tzu Chi offers an important avenue of service for adherents to the Taiwanese Buddhist tradition.
- Their beliefs and commitment to a compassionate response translate into a structure and capacity that make them more agile than many other institutions and government organizations.
- Public health partners, recognizing these strengths, can help build them with organizations that have similar kinds of commitments to a compassionate response, when and wherever needed.

Making the Model Work For You
While the Model Practice Elements seem ideal, how does it look in reality? When building faith-health partnerships, it is important to ask the following questions and think about your capacity and the partners’ capacity: How would these elements help you identify new partners that would be instrumental in reaching target populations? What pressing concerns would be shared by these partners? How could this build trust in more challenging areas? In the following section, two faith-health partnerships are presented as examples of the Model Practice Framework in action.
State health departments are large and can reach a broad audience. FBOs are typically local, and can translate information to fit specific community needs and capacities. They are not always ecclesial entities: they might utilize intermediaries, go between structures, and identify effective and available partners as a civic way of understanding their call. These partnerships aren’t a way for religion to try to convert public health, or vice versa: they are about finding people who care about target groups and are already acting on their behalf and shaping their lives with messages and meaning.

PLENARY SESSION 3: EXAMPLES OF PARTNERSHIPS IN DIFFERENT GEOGRAPHIC SETTINGS
Introduction
Every community and partnership has different needs and priorities. In this section, we discuss two examples of successful faith-health partnerships to better illuminate the Model Practice Framework. South Brooklyn Interfaith Coalition for Health and Wellness made a commitment to build partnerships with various religious organizations to bridge many cultures, and built a relationship with New York City’s health department to identify areas of highest need. Methodist Le Bonheur Healthcare and The Congregational Health Network have trusted relationships with faith-based organizations. The Congregational Health Network has effectively acted like a health department, identifying vulnerabilities, tracking rates of diseases and treatments, and addressing health disparities in its communities.

South Brooklyn Interfaith Coalition for Health and Wellness
Brooklyn has a large, diverse population that includes seemingly every ethnicity, culture, religion, nationality, and socioeconomic class. It is the most populous of the five New York City boroughs, with 2.5 million people. Brooklyn is in the midst of a huge gentrification wave, but 22 percent of families and 25 percent of non-families live below the poverty line. Within last decade, five major medical centers shut down and two more are in the process of shutting down, which has caused problems with access to primary healthcare and increased ER wait times.

Population
- 42.8% Caucasian
- 34.3% African American
- 19.8% Hispanic or Latino
- 10.5% Asian
- 3% Multi-Racial
- 8.9% Other Races

Income
- Median Income: $32,135
- Median Family Income: $36,188
- Per Capita Income: $16,775
- 22% of families live below the poverty line.
- 34% of individuals living below the poverty line are under 18.
- 21.5% of individuals below the poverty line are 65 or older.

Demographics
- Median Age: 33
- 22.3% of households are female-headed.
- 33.7% of households comprise non-families.
- 33.3% of residents are under 18.
- 9.8% of residents are 65 or older and living alone.
South Brooklyn Interfaith Coalition

South Brooklyn Interfaith Coalition for Health and Wellness (SBICHW) was formed in 2005 by clergy members in South Brooklyn to address and improve the health of their members and communities, especially the large at-risk vulnerable population. SBICHW operates out of the Lutheran HealthCare-Family Health Centers’ Office of Mission and Spiritual Care. Lutheran Healthcare was founded in 1883 and provides resources to the coalition including staff, supplies, educational materials, medication standing orders, and technical support.

Foundational Health Platform

The SBICHW utilizes a foundational health platform founded on three elements: a faith-health Connection, health ministry, and faith community nurse model.

- **Faith-health connection** incorporates cultural outreach when setting up health events. These are culturally sensitive and targeted for different religions. Scriptural quotes tying together faith and health are found in many religions including Christianity, Judaism, and Islam, and these are used in health bulletins and by religious leaders.

- **Health ministry** focuses on the healing and health needs of FBOs and the extended community. This ministry highlights the relevance of faith upon health, and incorporates a whole person approach of mind body and spirit.

- **A faith community nurse** is a hospital-sponsored nurse responsible for health issues that the community needs or feels is important. The faith community nurse works as a health educator, personal health counselor, referral agent, health advocate, volunteer trainer, support group developer, and integrator of faith and health. In order to maximize her time and preform these many duties, the faith community nurse works to assess the community needs and capacities. The faith community nurse is change agent, training for different faiths then her own, so public health needs to be mindful of nuances in each religion in order to be respectful and effective.

Developing a Faith-Health Partnership

The process for developing a faith-health partnership requires sensitivity and collaboration. The foundational component is understanding the relationship between faith and health for the particular faith. Once that is understood, the next step is asset-based community development through discovering and mapping FBO and local assets, then connecting the assets to work together and creating opportunities for assets to be productive and powerful together.

Using Asset-Based Community Development Within FBOs

Asset-based community development (ABCD) has many benefits. It allows a partnership to achieve a lot with limited resources by bringing people to the table that can make the programs most functional. It also gives FBOs a sense of ownership and investment as it allows them to be the producers of services. If FBOs are invested and they can make change and feel heard at the table, partnerships will be more successful.

The primary building blocks for implementing ABCDs with FBOs are established through cooperative work with church leaders, health guild or ministry members, and church members. Meetings with the church leader should discuss his or her vision for the church ministry. It is important to develop a covenant which can be small or comprehensive, but which underscores the role of the church in the
partnership and has religious significance. The meeting should include a church assessment of space, staff, budget, school, food pantry, and computers, etc. which can be used to achieve the goals of the partnership. The next important relationship to cultivate is with the health guild or ministry members. These interviews can be one-on-one or group discussions, and should discuss their definition of health ministry and assess for skills, gifts, passions, health concerns, and schedule. Finally, ABCD incorporates the church members through a notice in the bulletin announcing the start-up of the church health ministry and request for healthcare professionals and lay volunteers, and a congregational health needs assessment.

In order to make ABCDs truly effective, the partnership must explore different community assets. All community sectors can bring something to the table. Community groups and networks can have a large pool of resources and assets, for example, a Brooklyn congregation that is connected to 400-500 churches. Local private businesses and economic assets should be explored, such as local pharmacies, which can be contacted to provide education. Governmental and non-governmental organizations also have an important role to play here, as they can provide emergency medical technicians and coordination for the community assets.

Development of Capacity Building Activities
Capacity-building activities are activities partners and organizations undertake to enhance the partnership’s effectiveness to improve health outcomes in ways that build on assets and resources. Activities and mobilization are actions steps that, with organization, will harness the relationships that exist within the community.

Activities: Action Steps
- Volunteer training
- Information dissemination
- Health fairs, “Pin a Sister Sunday,” activities, Bible study, flu clinics
- Networking with other FBOs
- Evaluation sessions

Mobilization: Action Steps
- Task force planning sessions
- Information dissemination
- Technical assistance
- Health presentations
- Community outreach
- Participation in studies

Desired Partnership Outcomes
SBICHW has five main desired outcomes:

1. FBOs will demonstrate and maintain healthy lifestyle behavioral changes.
2. The program will remain sustainable.
3. Healthcare disparities will decrease.
4. Access to quality healthcare will increase.
Meeting Summary

5. Going forward, SBICHW will have quantitative and qualitative data that demonstrate long term viability of this model.

Cynthia Davis, Methodist Le Bonheur Healthcare and the Congregational Health Network

*Methodist Le Bonheur Healthcare*

Methodist Le Bonheur Healthcare (MLH) is a network encompassing seven hospital systems with an annual budget of $1.4 billion and more than 10,000 employees. It fosters relationship-based care while providing health education and promotion that is culturally, ethnically, and religiously sensitive. The healthcare network covers a large area with substantial variations in socioeconomic status and demographics, and it is Tennessee’s largest provider of indigent care.

*History of MLH and the Congregational Health Network*

As early as 1999, MLH’s leaders were interested in ways that pastors could disseminate information concerning healthcare services that were relevant for them and their communities. This laid the foundation for partnerships between MLH and FBOs with a goal of reducing readmissions and improving the health of the community. In 2006, the Congregational Health Network was formed when MLH partnered with congregations and community organizations with the goal of improving access and health status for all.

*MLH and the Person-Centered Journey of Health*

The Congregational Health Network (CHN) considers itself a person-centered journey of health. CHN’s director works with 10 navigators who coordinate between the FBOs and the hospital. Navigators work with 520 churches, which have volunteer liaisons in each congregation. If a member of a CHN congregation goes to the hospital, a navigator is contacted who coordinates with the member’s congregation and liaison to ensure that the patient receives adequate follow-up care and has his/her questions answered after discharge.

*Outcomes*

Research on the MLH network has shown that CHN provides a significant benefit to institutions, communities, and individuals. CHN members have lower 30-day readmission and mortality rates than non-members, which is attributed to the network of communication, resources, and care that continues after a hospital discharge from the hospital. CHN members also have improved access to health fairs and preventive health measures, which results in savings for payers and hospitals, especially for conditions like diabetes. Since 2008, emergency department visits for CHN members have decreased 20 percent.

*State Action Plans*

The purpose of the meeting was to convene teams from Arkansas and New Jersey, comprised of individuals from both the state health agency and faith-based partners, to develop state action plans building on the strengths of these partnerships. The two states spent a day and a half working together to identify a goal or goals related to influenza prevention.

Led by an ASTHO facilitator and note taker, the state teams met separately. The four state team sessions provided Arkansas and New Jersey representatives the opportunity to identify their partnerships’ strengths and opportunities for enhancement to better meet the influenza prevention needs of at-risk, vulnerable, and minority populations in their communities. The teams identified at least one objective
related to influenza prevention and public health and faith-based partnerships as well as necessary action steps and team members to lead them.

Arkansas Action Plan
Arkansas’ state action plan (Appendix C) identified three goals. First, the team wished to improve immunization rates by 25 percent in 11 identified towns. Strategies to achieve this goal included:

- Reviewing current registration or intake forms to collect quality improvement data like ethnicity, race, or reasons for declining vaccination after attending.
- Piggybacking on existing initiatives like mobile vaccination clinics for transient populations and food banks.
- Developing marketing and communication materials to publicize the vaccination message.

Arkansas’ second goal was to identify champions and build infrastructure in the target towns. To achieve this goal, members of the team would:

- Offer cultural sensitivity trainings specific to each faith group via panel sessions for health department staff.
- Use and build on existing relationships in each of the target towns.
- Recruit existing champions to hold community meetings to recruit new champions.

Finally, the team set a goal to pursue formation of a statewide faith-based workgroup or coalition that is housed in the Arkansas Department of Health or Better Community Development. Strategic actions included:

- Developing a proposal and mission statement for a presentation to Arkansas Department of Health leadership.
- Engaging critical partners, including key health department programs, faith-based leadership, and existing faith-based clinics.
- Enhancing the relationship between Arkansas Department of Health and already existing FBO clinics.

Arkansas Accomplishments
The Arkansas team has made great strides in reaching their goals. In terms of their first goal, the Arkansas team was able to reach out and partner with 14 diverse faith-based and community-based clinics. In total, 311 individuals were vaccinated in these clinics, 51.13 percent of whom were male and 72.99 of whom were uninsured, indicating that vaccination efforts reached the targeted audience. The Arkansas team was also able to accomplish their second goal: eight of the 14 partnerships established were with churches and health ministries in the southeastern and southern part of Arkansas and 214 of the 311 vaccinated individuals were reached through these faith-based partnerships.

As for their last goal, the Arkansas team is still working on building a faith-based coalition. Efforts to identify a qualified leader, ideally from a partner faith-based organization, are currently underway. Throughout the project, the Arkansas team learned that communication, relationship building, education, and timely promotion of the flu clinics and vaccination events are critical for forming strong ties with partner organizations and gaining significant participation among its members. The use of marketing tools such as press releases and news bulletins, as well as scheduling clinics to coincide with
Meeting Summary

health fairs or other large events going on in church and community organizations were found to be effective strategies to achieve desired vaccination results.

New Jersey Action Plan
New Jersey identified two goals (Appendix D): to enhance their existing partnerships and to demonstrate their impact through data. To achieve the first goal, the members of the team decided to take stock of the partnerships they already had and work to improve them. Secondly, they decided to identify additional organizations with which to partner and begin to build those relationships. They decided to develop, and administer, and analyze a survey of participants in influenza vaccination events to help the team articulate their impact.

New Jersey Accomplishments
The New Jersey team was able to successfully accomplish both of their outlined goals. Influenza vaccination efforts and outreach were focused primarily in Middlesex County due to its significant racial and ethnic diversity and its highly developed community outreach ministry. After the team convened at the capacity building meeting, they outlined specific roles for everyone. Using their existing database of more than 2000 faith-based organizations as well as specific criteria and a needs assessment test, the New Jersey team was able to enhance existing partnerships and identify a preliminary list of “cultural brokers” in the targeted area of Middlesex. Additional sites in the faith community participating in the Walgreens program showed interest in collaborating and participating in the flu initiative and were identified as partners. The FBO Saint Peter’s Outreach also committed to provide flu vaccines through March 2014.

In terms of achieving their second goal, the team used a survey initially constructed in Minnesota to capture critical information from participants at the Walgreens location and other appropriate outreach sites. The survey was administered to approximately 8 percent (139 out of the 1823) of the program participants. The survey found that immunized individuals were predominately 30-40 years old, Hispanic/Latino, uninsured, would not have gotten the flu vaccine if it had not been administered at that site, and didn’t know where else to get a flu shot. The team learned that it was extremely important to administer the survey early and frequently in order to capture accurate data. Currently-available data represent estimates of the actual results and plans are underway to have a legal review of the survey completed.

The team found that incentivizing partners early with a stipend helped encourage broader survey participation. The New Jersey team also discovered that there is no system in place to record and archive vaccinations for adults, as race or ethnicity information has not been included in influenza case count reports and influenza-related death records. New Jersey is currently working to create a centralized repository for adult vaccinations and a system that records the race and ethnicity of all persons who died, were infected, or are vaccinated against influenza. Ideally this system will be accessible through mobile medical units and other non-medical facilities.
CONCLUSION
Faith-health partnerships provide an opportunity to leverage public health dollars to serve hard-to-reach populations by uniting the strengths of public health and faith-based organizations. While balancing the needs, capacities, and structures of all partners may be challenging, the provided model practices and case examples should provide guidance to building functional and effective partnerships. Such partnerships should identify what each partner does best, and together build a vision of the partnership based on their shared interest in reducing health disparities.
Meeting Summary

APPENDIX A
Meeting Agenda

Building Community Capacity to Prevent Flu through Faith-Based Collaboration

AUG. 12-13, 2013: CHARLESTON, SOUTH CAROLINA

The goal of the meeting is for teams to generate their own state-specific action plan which will help to build or enhance relationships with faith-based organizations (FBOs) to prevent influenza and build equitable health outcomes for communities. Outcomes from the meeting will include a state-conceived and developed action plan to address at least one barrier or challenge to providing influenza immunizations to racially and ethnically diverse communities and the opportunity to network with colleagues from other parts of the country who have successfully built and maintained public health and faith community collaborations to prevent influenza.

This meeting is designed to:
1. Provide background information on the benefits of partnering with FBOs to provide influenza immunizations.
2. Demonstrate the opportunities for such partnerships in diverse settings.
3. Provide an overview of the model practices framework for partnering with FBOs.
4. Give two states the opportunity to establish teams to enhance or expand their partnerships with FBOs in their jurisdiction to provide influenza prevention messages and immunizations.
5. Develop state team action plans to implement upon return to the respective jurisdictions.
6. Establish a network for support or technical assistance to state teams as needed/requested.

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00</td>
<td>Welcome and Introductions</td>
<td>Jim Blumenstock, ASTHO</td>
</tr>
</tbody>
</table>
| 9:15  | Plenary I: The rationale for public health and FBO partnerships | Mimi Kiser, Emory University’s Interfaith Health Program  
José González, Minnesota Department of Health, Office of Minority and Multicultural Health |
| 9:45  | Questions & Discussion                         |                                                                           |
| 10:00 | Break                                          |                                                                           |
| 10:15 | Plenary II: Model practices framework, what it takes to be successful | Mimi Kiser, Emory University’s Interfaith Health Program.                  |
| 10:45 | Questions & Discussion                         |                                                                           |
| 11:00 | Plenary III: Examples of how partnerships have developed in different geographic settings | Marilyn Bathersfield, South Brooklyn Interfaith Coalition for Health and Wellness  
Cynthia Davis, McKendree District of the Memphis Conference of The United Methodist Church |
### Meeting Summary

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:30</td>
<td><strong>Methodist Church</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Questions &amp; Discussion</strong></td>
</tr>
<tr>
<td>11:45</td>
<td><strong>Working Lunch:</strong> the process for the state teams</td>
</tr>
<tr>
<td>1:00</td>
<td><strong>State team breakout I:</strong> Identify challenges/barriers in reaching vulnerable and at-risk racially and ethnically diverse communities</td>
</tr>
<tr>
<td>2:30</td>
<td><strong>Break</strong></td>
</tr>
<tr>
<td>2:45</td>
<td><strong>State team breakout II:</strong> Establish at least two goals which addresses at least one of the identified barriers to achieve by December, 2013</td>
</tr>
<tr>
<td>4:15</td>
<td><strong>Break</strong></td>
</tr>
<tr>
<td>4:30</td>
<td><strong>State team breakout III:</strong> Identify action steps to be taken in order to address the first goal</td>
</tr>
<tr>
<td>5:30</td>
<td><strong>Dinner on your own</strong></td>
</tr>
</tbody>
</table>

**Day II**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00</td>
<td><strong>State team breakout IV:</strong> finish identifying action steps to be taken to address both goals (or more)</td>
</tr>
<tr>
<td>10:45</td>
<td><strong>Break/check out of hotel</strong></td>
</tr>
</tbody>
</table>
| 11:30 | **Plenary IV:** Sharing the state plans with each other and identifying the possible technical assistance needs to implement the plans  
                             Connie Jorstad, ASTHO |
| 12:15 | **Plenary V:** Moving forward- what to expect  
                             Connie Jorstad, ASTHO |
| 1:00  | **Meeting adjourns**                                                               |
Marilyn Bathersfield is a registered nurse in New York with over 27 years of healthcare experience in various areas of patient care (volunteer, nursing assistant, licensed practical nurse, EMT, and registered nurse). Marilyn is presently employed as a faith community nurse coordinator for South Brooklyn Interfaith Coalition for Health and Wellness, a faith-health partnership with Lutheran HealthCare/Family Health Centers; and also holds a senior clinical nurse position in the Department of Urology for NYU School of Medicine. Marilyn obtained her nursing degree in 2006 from Dorthea Hopfer School of Nursing in conjunction with Concordia College, and completed a certification in faith community nursing in 2009 from the International Parish Nurse Resource Center. She has future aspirations for a degree in public health. In addition, Marilyn is a member of the Health Ministries Association, Guyanese Nurses Association of America, Brotherhood of St. Andrew, and serves on the St. Luke’s Health Guild.

In her role as a faith community nurse, Marilyn is able to marry her two passions of healthcare and spirituality as she encompasses a holistic approach to health and healing: mind, body and spirit. She is actively involved in community health initiatives and over the last four years has cultivated mutually beneficial relationships with departments of public health and private entities to provide health education, health screenings, and disease prevention activities that promote lifestyle behavioral changes within faith-based and community organizations. Marilyn shares the vision of the HMA, which is to engage, educate, and empower people of faith to be passionate and effective leaders for creating healthier communities.

James S. Blumenstock, M.A. Jim holds the position of chief program officer for public health practice for the Association of State and Territorial Health Officials (ASTHO). His portfolio includes the state public health practice program areas of infectious and emerging diseases, immunization, environmental health, public health preparedness and security (including pandemic influenza preparedness), and public health law. Jim also serves as a member of the association’s executive management team, responsible for enterprise-wide strategic planning, administrative services, member support, and public health advocacy.

Prior to his arrival at ASTHO in November 2005, Jim was the deputy commissioner of health for the New Jersey Department of Health and Senior Services, from which he retired after almost 32 years of career public health service. In this capacity, he had executive oversight responsibilities for a department branch of more than 650 staff, an operating budget of approximately $125 million, which was comprised of the Division of Public Health and Environmental Laboratories; Division of Epidemiology, Occupational and Environmental Health; Division of Local Health Practice and Regional Systems Development; Division of Health Emergency Preparedness and Response, and the Office of Animal Welfare. During his tenure, Jim also represented the Department on a number of boards, councils, and commissions, including the New Jersey Domestic Security Preparedness Task Force.

Jim is the proud recipient of the ASTHO 2004 Noble J. Swearingen Award for excellence in public health administration and the Dennis J. Sullivan award, the highest honor bestowed by the New Jersey Public Health Association for dedicated and outstanding service and contribution to the cause of public health.
Meeting Summary

He is also a Year 14 Scholar of the Public Health Leadership Institute and held an elected office serving his community for 12 years.

Jim received his Bachelor of Science degree in environmental science from Rutgers University in 1973 and his Master of Arts in health sciences administration from Jersey City State College in 1977. He is a native of New Jersey, which is still his primary residence with his wife of 39 years, Lee. They have three children and three grandchildren.

Dr. Cynthia Dianne Davis was appointed District Superintendent of the McKendree District of the Memphis Conference of the United Methodist Church in June 2011. Prior to this appointment, she served for six years as senior pastor of Friendship United Methodist Church in Millington, Tennessee. She practiced nursing in various capacities for twenty-four years. Before entering full time ministry, she served as manager of admissions and retention at Baptist College of Health Sciences in Memphis. Concurrent with her twenty-four years as a practicing registered nurse, she served as an African Methodist Episcopal (AME) pastor for one year, and for six years was an associate pastor of White’s Chapel AME Church. She also served for four years as an associate pastor in the founding of North Star Community Church and spent two additional years as a volunteer associate pastor for Asbury United Methodist Church. She has been an ordained elder of the AME Church since 1997 and her orders were transferred and received as a member in full connection of the Memphis Conference of the United Methodist Church in June 2010.

Dr. Davis began her college education at Tuskegee Institute and received her Bachelor of Science in nursing from the University of Mississippi Medical Center and her master’s degree in Counseling from the University of Memphis. In December 2005, Dr. Davis received her Master of Divinity Equivalency and Doctor of Ministry degree along with her husband, Chaplain Elvernice “Sonny” Davis, USA Retired, from United Theological Seminary. Her focus group was “The Black Church and Public Health.” Her dissertation is entitled, “Promoting Healthy Dietary Lifestyles to Prevent Obesity in African American Adolescents.” In May 2007 she completed an additional 16 hours at Memphis Theological Seminary, fulfilling final requirements for transferring into full connection as an elder in the UMC. She and her husband Sonny have four children and two grandsons, Jalen and Blake. She presently serves as a member of the board of trustees for Hannah’s Hope and the United Methodist Neighborhood Centers. She faithfully serves the Church on a variety of committees. She is a graduate of Leadership Memphis, Class of 2008.

José Gonzalez is the director of the Minnesota Department of Health’s Office of Minority and Multicultural Health (OMMH). He was born in Durango, Mexico and immigrated to Aurora, Illinois (30 miles west of Chicago) and remains bilingual and bicultural. He has a bachelor’s degree in psychology and a master’s degree in social work from the University of Minnesota. José has a variety of health and human service work experience, including county economic assistance and child protection programs, migrant farmworker support, child and adolescent inpatient psychiatric units, public health clinics (school-based, family planning, and prenatal care), and spoken-language interpreter programs. Prior to coming to OMMH he was a program officer with the Bush Foundation in Saint Paul. José also has served on numerous community boards and continues to serve on Robert Wood Johnson Foundation’s National Advisory Committee for the Local Funding Partnership.
Mimi Kiser is a senior program director for the Interfaith Health Program and assistant professor in the Department of Global Health at Emory University’s Rollins School of Public Health. She joined the Interfaith Health Program in 1993 during its first seven years at The Carter Center. Mimi has a background in community health nursing and health education. She teaches interdisciplinary courses at Emory in faith and health, religion and development, and social justice. Mimi has focused on building the capacity of health groups to form collaborative relationships with the faith community, specifically through networks such as the American Public Health Association’s Caucus on Public Health and the Faith Community, the Coalition for Healthier Cities and Communities’ Faith Action Team, and the Public Health Leadership Society. For six years she directed IHP’s Institute for Public Health and Faith Collaborations, which was funded by the CDC to provide multisector leadership development for the elimination of health disparities. Currently Mimi leads the Academic Programs Working Group for Emory’s Religion and Public Health Collaborative and is working with IHP colleagues in teaching and community mobilization activities supported by the CDC and HHS throughout the United States and in Kenya. In 2011 Mimi completed her doctorate in ministry at Wesley Theological Seminary focusing on “boundary leadership” within the faith and the health of communities track.
## Meeting Summary

### APPENDIX C

**State Action Plan**

**Arkansas**

<table>
<thead>
<tr>
<th>Participants</th>
</tr>
</thead>
</table>
| **Russ Breshears**  
Minister  
Oak Forest United Methodist Church | **Joy J. Carrington**  
Health Program Specialist II  
Office of Minority Health & Health Disparities  
Arkansas Department of Health |
| **Cassie Cochran**  
Planning Section Chief/ MRC State Coordinator  
Arkansas Department of Health | **Jennifer Sayles Medley**  
MRC State Coordinator  
Arkansas Department of Health |
| **Alassad Rasheed**  
Director of Community Wellness Programs  
Community Development | |

### Concerns/Gaps:

- Communication dissemination plan
- Congregation’s size affects/limits its reach
  - Strategy:
    - using Methodist district office to identify appropriate congregations.
    - finding the right people with the right database
- POD planning for rural populations
  - Strategy:
    - identifying and using churches
- Working with churches that do not already work in health
  - Food bank connection
- Identifying community needs in red counties
  - Strategy:
    - plans should include red counties
    - identify counties to focus on
    - Southern counties: Dallas, Ouachita, Union
    - Northeast counties: Mississippi, Springdale and Washington (Marshallese)
- Location of service sites
- Limited staff hours in FBOs
- Agreement on minority labeling (racial, ethnic, income, age)
- Lack of coalitions
- Matching PHEP resources with OMH resources

### Action Plan
**Goal One:**
Improve immunization rates by 25% in the identified towns: Pope, Yell, Dallas, Ouachita, Union, Mississippi, Pulaski, El Dorado, Denton, Osceola, Blighville.

**Strategies:**
1. **Review current registration/intake forms to collect quality improvement data, such as ethnicity, race, and reasons for declining vaccination after attending.**
2. **Piggyback on existing initiatives, such as mobile vaccination clinics for transient populations and food banks.**
3. **Develop marketing and communication materials to get the message out.**

- Review current registration/intake forms to collect quality improvement data, such as ethnicity, race, reasons for declining vaccination after attending, etc. (similar to the Minnesota survey).
  - Add survey questions to intake forms for race/ethnicity, age and those not wanting vaccine. (Joy, Jennifer)
  - Cost center, IO#. (Joy)

- Piggyback on existing initiatives, such as mobile vaccination clinics for transient populations and food banks.
  - Ensure availability of extra vaccine if needed and weekend staff (Cassie) – 1st step.
  - Contacts for the 3 counties in the south for the mobile PODs for transient populations (All: Cassie, Joy, Jennifer, Russ, Allassad) – during the next week.
  - Develop marketing/communication materials, yard signs, and scripture verses for the food bank contacts. (Breshears, Rasheed, Jennifer)
  - Need to assign a health unit to deliver vaccine after hours to the 3 south counties. (Cassie)
  - Logistics for repacking vaccine between clinics (e.g. dates) – for 2nd week in November (10th-16th). (Cassie)
  - Use freebies/giveaways to incentivize the event. (Cassie)

- Develop marketing and communication materials to get the message out
  - Meet to develop marketing and signs. (All: Cassie, Joy, Jennifer, Russ, Allassad)
  - Inform local counties and relevant issue champions. (Cassie, Joy)
  - Messages should include what ADH gets from partnering with FBOs and what’s in it for the faith communities:
    - Communication examples: What ADH gets from partnering with FBO
      - Need to explain what public health is outside of inspections and other stereotypes. Opportunity for FBOs to advance awareness of what public health is.
      - An entrée into a system that has been mostly closed to health in terms of providing health services.
      - Dr. Rasheed has language from meeting; invited to speak on engaging FBOs in health.
      - Untapped volunteers, community access/trust, community/cultural knowledge.
      - Healthier congregation is a health Arkansas.
Meeting Summary

- What’s in it for the faith communities
  - Grants, ability to get data and do studies on issues affecting communities.
  - Invite other faith leaders to visit FBO clinics to see practical examples of benefits from partnership.
  - Potential for membership recruitment through FBO clinics.
  - Opportunities for congregation members who like to serve.
  - Health resources for addressing mental health issues – preparedness disaster plans have volunteer counseling service partnerships.
  - Resources for addressing nutritional issues: Cassie and Joy have connections, city of Little Rock grant, Cassie is an instructor for other grant. FBO can fit it to religious/scripture-based teachings.

Goal Two: Identify champions and build infrastructure in the target towns

Strategies:
1. Offer cultural sensitivity trainings specific to each faith group (panel sessions for health department staff).
2. Use and build on existing relationships in each of the target towns.
3. Recruit existing champions to hold community meetings to recruit new champions.

- Offer cultural sensitivity trainings specific to each faith group (panel sessions for health department staff).
  - Find cultural sensitivity trainings. (Cassie, Breshears, Rasheed)
  - Set up gift for speakers and check/reserve auditorium for October trainings, less than 1.5 hour each, lunch time, distance learning capabilities. (Cassie)
  - Contact speakers for panels:
    - Imam – Islam (Rasheed)
    - Chad/Cathy – LGBTQ (Cassie)
    - Buddhist – A Stewart (Breshears)
    - Jewish
    - Rupa, Nepalese Society – Hindu (Rasheed)
    - Aunt Chaplain/Hospice (Jennifer)
    - Transgender person (Jennifer)
  - Inform HR about the training and about assisting with attendance.

- Use and build on existing relationships in each of the target towns.
  - Contact:
    1. Bishop Felton May (Rasheed)
    2. Bishop Matheny (Rasheed)
    3. Rev. Hezekiah Stewart
    4. Roger Glick, Salvation Army (Cassie)
    5. Presbyterian church contact
    6. Judy Smith, Camden (Rasheed)
    7. Housing guy in Camden (Rasheed)
    8. Superintendent Jones (3rd District) (Rasheed)
Meeting Summary

9. Peggy, food bank
10. Governor’s office person
11. Ronda Stewart
12. Parish nurse
13. 2nd Presbyterian LGBTQ (Joy)

- Meeting with community champions (All: Cassie, Joy, Jennifer, Russ, Alassad)

- Recruit existing champions to hold community meetings to recruit new champions.
  - Marketing plan: find out where champions might be through our existing champions.

Goal Three: Pursue formation of a state-wide, faith-based workgroup or coalition that is housed in the ADH or Better Community Development.

Strategies:
1. Develop proposal and mission statement for presentation to ADH leadership.
2. Engage critical partners, including key health department programs, faith-based leadership, and existing faith-based clinics.
3. Enhance the relationship of ADH with already existing FBO clinics.

- Develop proposal and mission statement for presentation to ADH leadership.
  - First, put together proposal. (All: Cassie, Joy, Jennifer, Russ, Alassad)
  - Get on ADH leadership’s agenda. (Cassie, Joy)
  - Take the proposal to ADH leadership by December 31. (All: Cassie, Joy, Jennifer, Russ, Alassad)

- Engage critical partners, including key health department programs, faith-based leadership, and existing faith-based clinics.
  - Include leadership from:
    - Immunization
    - Minority Health
    - Chronic Disease
    - Hometown Health Improvement
    - Smoking
    - Environmental Health
    - HIV
    - Preparedness
    - Better Community Development
  - Include Faith-Based Leadership from (Breshears):
    - Tahid Salaam
    - Baptist
    - Assembly of God
    - VOAD
    - Sororities/Fraternities, e.g. Sisters United
    - Parish Nurses
### Meeting Summary

<table>
<thead>
<tr>
<th>Town (Red County)</th>
<th>Unvaccinated Adults</th>
<th>Unvaccinated African Americans</th>
<th>Unvaccinated Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dallas</td>
<td>15.9%</td>
<td>41.9%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Ouachita</td>
<td>46.6%, ranked #5</td>
<td>40.1%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Union</td>
<td>34.1%, ranked #4</td>
<td>33%</td>
<td>16%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>38.9%, ranked #5</td>
<td>34%</td>
<td>12.2%</td>
</tr>
</tbody>
</table>
APPENDIX D
State Action Plan
New Jersey

Participants

<table>
<thead>
<tr>
<th>Tabiri M. Chukunta</th>
<th>M. Carolyn Daniels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Director, Community Outreach</td>
<td>Executive Director, Office of Minority</td>
</tr>
<tr>
<td>and Diversity Initiatives</td>
<td>and Multicultural Health</td>
</tr>
<tr>
<td>Saint Peter’s Healthcare System</td>
<td>New Jersey Department of Health &amp; Senior</td>
</tr>
<tr>
<td></td>
<td>Services</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Deborah Gash</td>
<td>Tara Gunthner</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>Saint Peter’s University Hospital</td>
</tr>
<tr>
<td>Middlesex County Office of Health</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Suzanne Miro</td>
<td>Elizabeth Williams-Riley</td>
</tr>
<tr>
<td>Sr. Health Communications Specialist</td>
<td>President &amp; CEO</td>
</tr>
<tr>
<td>Communicable Disease Service</td>
<td>American Conference on Diversity</td>
</tr>
<tr>
<td>New Jersey Department of Health &amp; Senior</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
</tr>
</tbody>
</table>

Current Initiatives

- Immunizations have decreased greatly. We don’t know if people are getting it privately.
- Have not heard of resources issues (it is distributed and there are vaccines) but people aren’t seeking it; need to find out who doesn’t want it and why.

Concerns/Gaps

- Access: Cost to participant, convenience, lack of provider advocacy/provide vaccines. Children are required up to age 6 to get vaccinated and then there is drop-off and more disparity among adults. Vaccine cost: $15 or Medicare. Free flu vaccine for STD clinic but that is a limited group. VFC comes to us through STD clinic. There’s a population that can’t afford it and we’re making the choice to throw it away rather than give it away. In January it’s free but no one cares by then.
- Policy: no policy in place to give unused vaccine away; lack of awareness by policy makers; uninsured population issues; insufficient data and stories – need to identify current data sources and create new ones and “marry stories with data.”
- Tracking: Have state immunization registry: any entity that provides vaccine can enter it but it’s not required. Pediatric is entered but adults are not mandatory. All VFC vaccine has to be entered – there’s a piece of VFC for adults that have to be entered into system in order to get vaccine back. Don’t have a central database and doesn’t break down by race/ethnicity; can be addressed through policies.
- Communications: Cultural and linguistic competency; health literacy, lack of social marketing – need media to help get messages out.
Meeting Summary

- Perceptions: Medical distrust of vaccine; efficacy issue and fear that the vaccine will do harm. Depends on how it’s presented, and how it’s made available to some but not others. Example: Herbal medicine has a large population in New Jersey. Fear that vaccines cause autism (prevalent in Somali community); undocumented population fear.
- Partnerships: Not knowing the key stakeholders; need to identify “cultural brokers”; need to add religious advisor to core group.

Action Plan

Overarching Goal: Increase engagement with partners to maximize uptake of influenza vaccine in target populations in Middlesex County.

Goal One: Enhance partnerships

<table>
<thead>
<tr>
<th>Strategies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enhance existing partnerships</td>
</tr>
<tr>
<td>2. Develop new partnerships</td>
</tr>
</tbody>
</table>

- **Enhance existing partnerships**: Identify and contact partners in targeted areas of Middlesex using developed criteria (reach, population, influence, trusted, diverse, places of worship, other FBOs); conduct needs assessment of partners.
  - Identify potential partners from database (Elizabeth, Carolyn, Tabiri) by August 23, 2013.
  - Reach out to partners and invite them to participate (Elizabeth, Carolyn, Tabiri) by September 9, 2013.
  - Loop back with advisory group after partners are identified and after partners are contacted. (All)

- **Develop new partnerships**: Identify and contact “cultural brokers” who have not already been identified as partners.
  - Identify gaps, cultural brokers who address gaps, and contact cultural brokers (Carolyn, Tabiri, Deborah) by October 31, 2013

Goal Two: Demonstrate impact through data

<table>
<thead>
<tr>
<th>Strategies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop and administer a survey</td>
</tr>
</tbody>
</table>

- **Develop and administer a survey**
  - Define goal of survey (All) by August 23, 2013
  - Review existing surveys from New York and Minnesota (All) by August 23, 2013.
  - Develop survey in English, Hindi, and Spanish (All) by August 23, 2013
### Meeting Summary

- Administer survey (Carolyn, Tabiri, Deborah, Suzanne) on paper and electronically.
  - Onsite survey at St. Peter’s on September 28, 2013
  - Onsite survey at county events during October 2013
  - Onsite survey at places of worship during January 2014?
- Data evaluation (Suzanne) by the end of February 2014.