EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH | Interfaith Health Program
Hubert Department of Global Health

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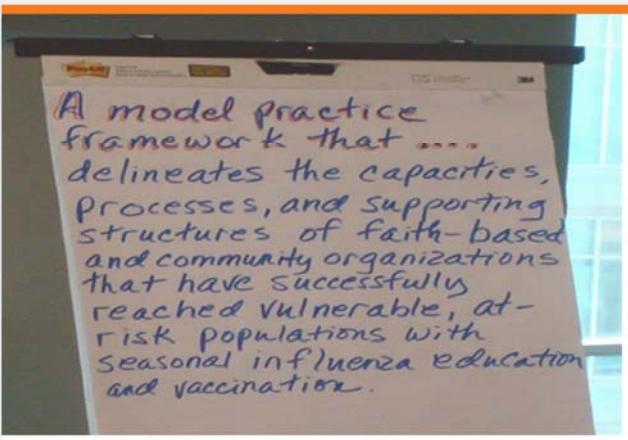
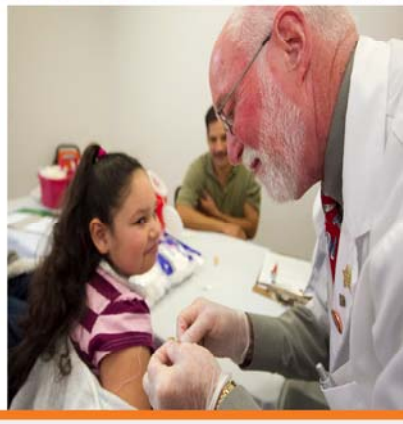
# Public Health and Faith Community Partnerships:

## Model Practices to Increase Influenza Prevention Among Hard-to-Reach Populations





A RESOURCE GUIDE AND TOOLKIT FOR PUBLIC HEALTH AGENCIES

SPRING 2014

# FOREWORD

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Dear Colleague,

The central mission of public health is to assure the health and safety of all communities across our nation. Public health cannot achieve this mission alone; increasingly, practitioners and policymakers are recognizing the important role diverse community partners can play. When public health must reach the most at risk and the most vulnerable, faith-based organizations are of vital importance. Whether public health agencies are responding to pandemics, other public health emergencies, or seasonal influenza each year, faith-based organizations can help.

While partnerships between public health and faith-based organizations are not exactly new, they are receiving a renewed focus at all levels of government. ***Public Health and Faith Community Partnerships: Model Practices to Increase Influenza Prevention Among Hard-to-Reach Populations*** is a new guide resulting from a fruitful partnership between ASTHO and the Interfaith Health Program at the Rollins School of Public Health at Emory University. This guide will be helpful for those in your agency who work to build community partnerships or conduct community outreach.

For many public health agencies, the value of working with faith-based organizations is evident. As with any partnerships, however, engagement with faith-based organizations cannot be broached with a one-size-fits-all approach. Nor should a public health agency assume all faith-based organizations share a mutual interest in the same health issues. There is a diversity of faith traditions, organizations, and structures. This guide provides an overview of the types of faith-based organizations (page 3) and the possibilities for linkages and partnerships with each. Potentially complicating these relationships are perceptions related to separation of church and state. The guide includes an overview of government and faith community partnerships addressing that issue (page 5).

The heart of the guide is the model practices framework analysis of a network of 10 sites from across the United States, each of which works to increase influenza prevention messages and vaccinations each flu season. This analysis yields a framework for looking at and assessing the nature of the relationships an agency may already have in place or those they seek to develop. The analysis presents the foundation, process and activity, and infrastructure elements present in each of the 10 sites.

We hope you find this guide useful and look forward to hearing about your success stories as you build partnerships or strengthen those already in place with faith-based organizations in your communities.

Sincerely,

Maxine Hayes

Maxine Hayes, MD, MPH, Washington State Health Officer (Retired)

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## Purpose

This Model Practices Framework provides strategies to identify and engage faith-based organizations (FBOs) as partners in community health promotion and disease prevention outreach. Designed for both public health and religious leaders, this guide aims to strengthen partnership-building capacity and enhance public health's ability to reduce the spread of influenza.

Increasingly, public health agencies recognize the importance of working collaboratively with nontraditional partners. This guide contains a set of model practices commonly employed across a network of 10 diverse health, faith, and community-based organizations that reached large numbers of vulnerable, at-risk, hard-to-reach, and minority populations with influenza prevention services. These seasoned practitioners have worked with the Interfaith Health Program (IHP) at Emory University and the Association of State and Territorial Health Officials (ASTHO) to describe community-based practices that uniquely engage the social, structural, and leadership strengths of faith-based organizations.

## Who Is the Guide For?

If your work includes partnership building or community outreach in a public health agency or healthcare organization, you may already have collaborative relationships with faith-based organizations or you may want to build them.

This guide is designed to assist you in strengthening existing relationships and ensure optimum success in building new ones.

If you are part of a faith-based organization that collaborates with public health and healthcare organizations, the guide is also designed to strengthen successful partnerships and to help you identify the unique capacities the faith community can contribute to achieving public health goals.

The leaders whose work this document represents share a commitment to eliminating health disparities. Therefore, the partnership-building capacity addressed in this guide should be of particular interest and value to those who want to build partnership relationships that break through cultural, trust, and resource barriers in order to achieve health equity.

## How Can the Guide Be Used?

The Model Practices Framework is made up of 14 essential practices organized as "Foundation," "Processes," and "Infrastructure." If you are developing community-based strategies to address a key health disparity, use these essential practices to assess capacity and plan collaborative action. Begin by recognizing that new partnership relationships and/or new capacities are necessary to overcome barriers to achieving health goals for particular populations.

Taking into account the priority health issue(s) to be addressed:

- ✓ Review the essential elements of the Model Practices Framework and determine which capacities could be instrumental in achieving progress. The five processes are the most useful starting point for this initial assessment.
- ✓ If these kinds of practices would likely improve efforts to address your community's health challenges, the next step is to assess your current capacity for implementing these practices. Each of the practices has a definition and several indicators that describe how to recognize and/or build that capacity. Again, initially examining the five processes is likely your best starting point.
- ✓ Next, this assessment can be used to either build capacity for existing partnership relationships or identify additional partners; the assessment also provides the approaches to use for that relationship development.
- ✓ At this point, integrate the practices identified as "foundational" and "infrastructure" into planning for capacity building and new partner identification as needed.
- ✓ Insights about the best partners for these kinds of collaborations can be gained by reviewing the organizations that participated in the Model Practices Framework development and the case examples linked to the practices that describe "Who Are the Key Players?" See "What Are FBOs?" on the following page as well.
- ✓ Use Model Practices Framework as an assessment tool in different stages of collaborative activities to determine effectiveness and identify which capacities may need further attention and development. This is not short-term work!

The next section provides information on FBOs, the religious landscape in the United States, and background on unique contributions FBOs can make to community health improvement efforts.

## What Are FBOs?

The faith-based organizations represented in the Model Practices Framework all have a history of working on health disparities in their communities. They work locally but also value being connected to a larger network of partners. Some are led by health professionals who are persons of faith adept at respectfully navigating the terrain of different cultural and religious environments. Others are led by religious leaders who understand health and wholeness as a part of their organization's mission.

All of them recognize their role in the public sphere as an important component of their responsibilities. They quite often function as intermediaries brokering organizational relationships.

A number of the lead organizations are faith-based health systems committed to reaching out to faith- and community-based organizations to ensure greater access to health resources for particular populations.

Some are smaller nonprofits with a mission and commitment to addressing the needs of the underserved. One is a federally qualified health center that has developed strong relationships with faith-based partners such as a Buddhist center and a network of congregations where large immigrant populations worship.

Reaching out to faith-based partners requires an appreciation for the diversity of the religious landscape in the United States, the variety of religious institutional structures, and an understanding of the likely players in the public sphere.

## Diversity of the U.S. Religious Landscape

The characteristics and activities of organizations with a religious identity and a public mission vary from community to community, state to state, and region to region. It is helpful to understand the variety of institutional structures that can function as intermediaries in the public sphere and as public health partners.

FBOs are best described across a spectrum, from large-scale to regional to local. Examples are provided in the table on the following page of the organizational structure that might be found at each level and possible health programming access points where a health organization may find a partnership contact.

# TYPES OF FAITH-BASED ORGANIZATIONS

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| Level | Organizational/ Structural Examples | Possible Health Program Links and Points of Partnership |
|---|---|---|
| National Associations | National Association of Evangelicals, Islamic Society of North America, World Union for Progressive Judaism, National Council of Churches | • May have an office for health programming that is connected across related denominations<br>• May have religious leaders who are champions of particular national or global health issues |
| National Religious Bodies | Christian (Catholic, Southern Baptist, United Methodist, National Baptist Convention, Assemblies of God, etc.), Islamic branches (Shia and Sunni are the largest), Judaism (most within 4 branches or movements), Buddhism movements or schools (many within 3 major divisions) | • May have health program offices<br>• Varied denominational structures lead to different institutional and administrative ties across congregations within all faith traditions.<br>• May have little or unpredictable "trickle down" dissemination impact<br>• However, policy positions and resources from the structure can support and reinforce local actions |
| Middle Judicatory Regional | Synods, conferences, districts, dioceses, archdioceses, councils, provinces, presbyteries, conventions, unions, societies, etc. | • Organizational structures that more closely link congregations and faith-based organizations—clusters of states, a state, large metro area, or portion of state.<br>• May also have a health program office and staff<br>• Identifying a religious leader with a vision for an institutional role in the health of communities is often key to the success of public health partnerships. |
| Local Congregations | More than 300,000 worshipping congregations of all faiths in the United States, actually a small portion of religious institutions) | • Majority have fewer than 200 members<br>• Some have health ministry programs<br>• Estimated > 10k faith community nurses in the United States<br>• Not all congregations are linked to a denominational structure<br>• Varied approaches to civic/public engagement<br>• Some have spun off community outreach service organizations |
| Local Ecumenical or Interfaith Agencies | Regional or state councils of churches, ministerial alliances, interfaith AIDS networks, Council of Islamic Organizations of Greater Chicago, Jewish Community Relations Council | • May have a health program and/or health partners; also may have a champion leader who is an advocate for a health issue<br>• May have special interests in certain groups or issues—children, violence, prisons, interfaith dialogue |
| Parachurch Organizations | Habitat for Humanity, Bread for the World, Heifer International, World Vision, Young Men's or Women's Christian Association, Aga Khan Foundation | • Many are focused on global reach<br>• All are linked in different ways to congregations for resource support |
| Charitable Aid Organizations | Catholic Charities, Lutheran Services in America, Islamic Relief, Church World Service, Salvation Army, American Jewish World Service, Jewish Social Service Agency, Buddhist Tzu Chi Medical Foundation | • Many combine domestic and global program work<br>• All reach beyond those of their tradition to serve people in need<br>• Are ideal public health partners when interests intersect |
| Seminaries and Higher Education | Association of Theological Schools (ATS) is a membership orgranization of over 270 graduate schools. Numerous other rabbinical and bible schools | • Academic partnerships between schools of public health and seminaries have participated in IHP's Faith Health Consortium<br>• A number have programs that address seminarian/future clergy health |
| Hospitals and Health Foundations | Nearly one-fifth of U.S. hospitals are religiously owned, and a majority are Roman Catholic sponsored. Religious healthcare assets are often converted to foundations. | • Often have strong community outreach programs with ties to congregations and faith-based organizations<br>• Conversion health foundations have legal mandates to serve the health needs of the underserved and are locally based |
| Diverse Community Ministries | Many have been started by congregations and gain 501c3 status. Most address specific issues or populations: race, health, youth, housing, jobs, food, substance abuse, mental health | • Often already engaged in partnerships<br>• Typically, small with minimal administrative and grants management type structure<br>• Ideal partners for tackling social determinants of health |

*The content of this table is an adaptation of the work of Dr. Eileen Lindner, editor of the "Yearbook of American and Canadian Churches"

## Likely Partners in the Public Sphere

The table on the previous page summarizes a wide variety of religious traditions and institutional structures. Keep in mind that this project has been most successful in mobilizing community resources to reach vulnerable, at-risk, and minority populations by working with local and regional organizations that have a long-standing history and commitment to working collaboratively in the public sphere on issues that are often important to and align with health organizations' interests—safe neighborhoods, housing, education, food security, violence prevention, etc. Leaders and organizations with this kind of history are likely to have formed or be a part of of agencies that collaborate regularly with government, social service providers, and groups of different religious traditions.

Of course, some faith-based organizations have commitments that do not align with public health values and priorities. The achievements of the leaders who generated the Model Practices Framework and the history of the Interfaith Health Program have been built with those who serve the community, desire to reduce suffering, and seek well-being and health equity for all.

## Why Faith-Based Organizations as Partners?

In the 1980s and early '90s, Dr. William Foege, former director of CDC, worked with former President Jimmy Carter to build a national and global public health agenda and program for The Carter Center. With a vision of "closing the gap" in glaring health disparities among different communities, Foege worked to bring religious institutions to the table to work with public health practitioners.

Grounded in that vision, the Interfaith Health Program was created to mobilize these groups toward a common goal with a transdisciplinary approach.

Increasingly, practitioners and policymakers are recognizing the important role FBOs can play in many policy areas. The White House has convened an office focusing on such partnerships. Public health practitioners in many areas, infectious disease prevention in particular, are also recognizing the important role these organizations can play in reaching those most at risk for and vulnerable to the spread of and harm from infectious diseases.

The practices presented in this toolkit have grown out of Foege's vision and these commitments.

## The Evidence

As a resource alongside public health, religious institutions have three distinctive qualities that are salient to partnerships aimed at eliminating health disparities.

- First, in most parts of the country, congregations, faith-based agencies of different kinds, and religious healthcare systems are pervasive in the social-structural landscape of communities.
- Second, they hold a kind of trust that creates unique access to particular populations.
- Third, they have values and commitments that quite often (though not always) align with and can contribute to public health goals.

Undergirding these claims is a strong body of research on both social determinants of health and the impact of partnerships on community health. Over the last 30 years, the knowledge generated by public health and social science research has led to a greater appreciation for and use of a social determinants approach to understanding and shaping public health interventions.

> "Three broad categories of social determinants are social institutions—including cultural and religious institutions, economic systems, and political structures; surroundings—including neighborhoods, workplaces, towns, cities, and built environments; and social relationship—including position in social hierarchy, differential treatment of social groups, and social networks."
>
> Anderson et.al., The Community Guide's Model for Linking the Social Environment to Health, 2003

As a social-structural determinant of health, religious institutions may function as important contributors of both social capital and community resilience that lessen barriers of mistrust. They can also respond in agile ways when public health and other government agencies cannot. This was the case in the aftermath of Hurricane Katrina in the South and in Los Angeles during public health H1N1 vaccination efforts in African-American communities.

The faith community is often considered an environment where healthy behaviors of individuals can be supported. This toolkit focuses on faith communities as important social institutions that can act when community-scale disease prevention and responses are needed.

## The Evidence [CONTINUED]

In 2012, the Institute of Medicine called for "significant investments in partnership-building capacity" as "mission-critical capacity development" for public health.

Partnerships and the communities' capacity to align their resources towards a common purpose are now accepted as essential to achieving public health goals. Recognizing this imperative in tackling the undergirding determinants of health disparities, IHP developed the Institute for Public Health and Faith Collaborations (IPHFC). The Institute's overall aim has been to strengthen organizations' collaborative relationships across sectors. The practices described in this toolkit are based on the work of exemplar community leaders who participated in the IPHFC and continue to hone their partnership-building capacities.

A related and substantial investment has been made by CDC in the development and evaluation of interventions aimed at eliminating health disparities through an initiative known as Racial and Ethnic Approaches to Community Health (REACH). Through these efforts, eight key principles and supporting activities have been identified as essential to successful health disparities achievements. Three of the REACH key principles are:

- **Trust.** Build a culture of collaboration with communities that is based on trust.
- **Trusted organizations.** Enlist organizations within the community that are valued by community members, including groups with a primary mission unrelated to health.
- **Community leaders.** Help community leaders and key organizations forge unique partnerships and act as catalysts for change in the community.

The practices described in this toolkit demonstrate the faith community's capacity as a social determinant of health—ones that can build and mobilize vital kinds of partnership relationships to ensure that disease prevention and health promotion services reach those who need them the most.

## Government and Faith Community Partnerships

Over the last two decades, there has been a renewed commitment to strong partnerships between faith communities and government programs.

- In the 1990s, the limitations of a government-supported social safety net led to the "Charitable Choice" legislation, which sought to level the playing field to include faith-based organizations as recipients of government funding and as providers of social services.
- In 1997, CDC, under the leadership of David Satcher, MD, PhD collaborated with the Interfaith Health Program to sponsor a day-long forum on "Engaging Faith Communities as Partners in Improving Community Health."
- The Bush administration created the Office of Faith-Based and Community Initiatives, which continues in a reconfigured form in the Obama administration as the Office of Faith-Based and Neighborhood Partnerships.
- There are now 13 federal departments with faith-based offices, and many states have created similar offices, linking health and human service agencies to engage the faith community.

Per the 2010 Executive Order, the 13 federal department offices have the responsibility to promote "compliance with constitutional and other applicable legal principles, and to strengthen the capacity of faith-based and other neighborhood organizations to deliver services effectively to those in need . . .". Government agency participation and support of faith-based programming must follow three legal obligations set forth by the Supreme Court:

First, the program must have a valid public health purpose that meets public health priorities that are addressed using strong public health intervention methods.

Second, the impact should neither foster nor hinder religion. Its primary impact should be achieving public health goals. Opportunities to participate in public health programming and access to government resources must be made equally available to different religions and nonreligious groups, whichever is best equipped to assist in meeting public health goals. For example, public health agencies may target religious groups that are best equipped to reach populations most impacted by health disparities. As resources become available and health priorities change, they can be extended to other faith community partners. Resources or funds should not be used for religious activities such as prayer, worship, or religious teaching, and these activities should be separated in time or location from programs that receive direct federal support.

## Government and Faith Community Partnerships [CONTINUED]

Third, the program should not foster excessive government entanglement with religion. Government resources should be kept separate from those used for religious purposes and be managed in a way that requires minimum oversight and administrative involvement across sectors.

The Minnesota Immunization Networking Initiative (MINI) project collaborates closely with the Minnesota State Department of Health and implements vaccination events that are "faith-placed" versus "faith-based." The flu clinic settings may be in congregations, but health funds are used for vaccine, supplies, promotional materials, vaccine administration personnel, and the like. This is all clearly delineated in the grant application.

The faith community has been and can be a very important partner in achieving public health goals. This may require use of government public health funds or may be limited to partnerships with governmental public health agencies. Either way, these guidelines should not discourage collaboration but give helpful direction to ensure that the relationships are in accordance with the Establishment Clause and the Free Exercise Clause of the First Amendment.

### SUPREME COURT'S THREE-PART TEST:

1. The statute or other government action must have a secular purpose.
2. The principal effect of the action or statute must neither inhibit nor advance religion.
3. The statute or government action cannot foster excessive government entanglement with religions.

*Source: Lemon v. Kurtzman, 403 U.S. 602 (1971).*

## How Was the Model Practices Framework Developed?

During project year 2012-13, the Emory IHP's "Reaching Vulnerable Populations" utilized a practice-based discovery process using a modified Delphi technique to synthesize distinctive practices from across the 10 participating sites (site list on page 7). The purpose was to delineate essential practices associated with faith-based and community organizations that have successfully reached vulnerable, at-risk, hard-to-reach, and minority populations with influenza education and vaccination.

Over six months, the identification of essential practices was accomplished in this sequence:

- Document review and thematic analysis (four years of progress reports and presentations).
- In-person inductive identification of key elements of practice (four of 10 sites) to produce an initial list of 25 key elements and characteristics.
- Online survey to validate key elements and characteristics (16 respondents across 10 sites).
- Small group work comprised of representatives from nine sites working to develop definitions and operational characteristics.
- Further refinement of definitions and distinctive characteristics through conference calls with participating sites. This led to 14 practices combined into a relational model organized by foundational elements, processes, and infrastructure.

During August 2013, we collaborated with ASTHO to pilot test the model as a capacity building tool for two state health departments and their faith-based partners.

## 10 UNIQUE MULTI-SECTOR SITES

### Chicago, IL
- Center for Faith and Community Health Transformation (Advocate Health Care and University of Illinois at Chicago) and Chicago Area Immunization Campaign (CAIC)

### Colorado Springs, CO
- Penrose-St. Francis Health Services Mission Outreach

### Detroit, MI
- United Health Organization

### Los Angeles, CA
- Buddhist Tzu Chi Medical Foundation

### Lowell, MA
- Lowell Community Health Center

### Memphis, TN
- Methodist LeBonheur Center of Excellence in Faith and Health

### Minneapolis-St. Paul, MN
- Minnesota Immunization Networking Initiative (MINI)

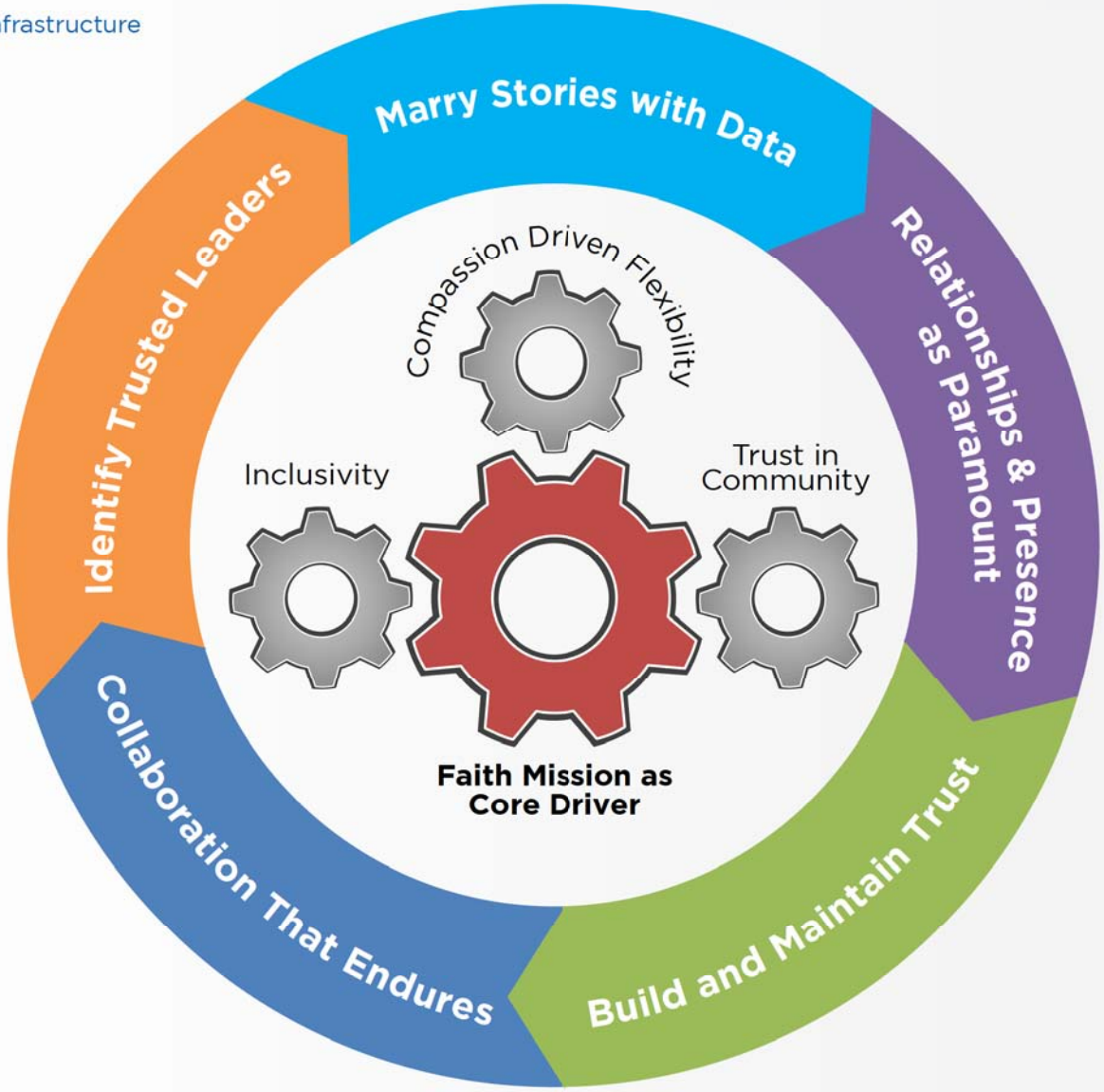
### New York City, NY
- South Brooklyn Interfaith Coalition (Lutheran Health Care)

### Schuylkill County, PA
- Schuylkill County's VISION

### St. Louis, MO
- Nurses for Newborns of Missouri

The Model Practices Framework as a schematic that represents the 14 essential practices organized as:

- The Foundation (CENTER)
- The Processes
- The Infrastructure



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## The Model Practices Framework

The Model Practices Framework describes commonalities across a network of faith- and community-based organizations and leaders who have worked for a number of years linking faith-based and health organizations in collaborative work to eliminate health disparities. These practices are divided into three categories: foundation elements, processes, and infrastructure.

As described in "How Can the Guide Be Used?", it is recommended that you review the following 14 practices and consider: how they may be useful in breaking through disparity challenges in the community you serve, what capacities would be important to build into your collaborative activities, what actions would enhance your success, and what additional partners would strengthen efforts to address health disparities in new and transformative ways.

## The Foundation

These first four practices are the foundation of the practices that drive the work. They describe what is unique to the faith-based character of this work and undergird its sustainable framework and sustaining qualities. One may find them in partnerships that have existed for some time. They may not be a beginning point in a new partnership, but the practices could serve as a measure to recognize qualities in collaborative relationships and possibly shape existing partnership goals. At some point, all other practices depend on and are fostered by these core drivers.

### Faith Mission as Core Driver

Definition: This collaborative work is grounded in beliefs and principles that sustain energy, motivation, and commitment to serving the collective good.

#### How does one recognize and build this?

- The values of sacred calling and meaning in the work are made explicit in the organizational and collaborative environment—when possible, prayer, devotion, mission made visible.
- Diverse religious traditions are recognized and embraced and a mutually held commitment to caring for all people is intentionally identified.
- Caring for all people means an explicit and shared commitment to seeing and knowing the most vulnerable and those on the margins and acting on their behalf.

### Trust in Community

Definition: A shared investment in and with the community is achieved out of foundational beliefs in the capacity and self-determining agency of the community.

#### How does one recognize and build this?

- A willingness to invest in the community for mutual gain is cultivated by an invitation for all to serve.
- Community members and organizations know their voices and agency matter and their priorities drive the work.

#### Case Example: Center for Faith and Community Health Transformation in Chicago

Our strong and large partnership network has a unique communication capacity with trusted messengers and translated, accessible, whole person health information. We collaborated with one of our partners, the Council of Islamic Organizations of Greater Chicago, on the development of a flu prevention message that is framed by the commitments and theological perspectives of their faith tradition. It was distributed through their e-newsletter that has a reach of more than 9,000 readers.

FAITHFULLY PREVENT THE FLU
Purity and cleanliness is central to Islam. During each flu season, the vulnerabilities to great suffering, including potential hospitalization and death, remind us that our spiritual journeys demand attention to the messy world around us. Vast disparities in health conditions and access to health care resources result in vulnerable populations' disproportionate suffering.

#### Case Example: Methodist LeBonheur Healthcare's Center of Excellence in Faith and Health in Memphis

From day one, the health care system partners have taken seriously and acted on what the religious leaders consider priorities for the community.

These leaders developed the founding covenant that guided the relationship between the congregations and the healthcare system through the Congregational Health Network.

Community priorities drive the work and the congregations understand they are an integral part of the community health system. Clergy were vaccinated first during 2009 H1N1 and named "First Responders," which represented their true role in the community.

# The Foundation

## Compassion-Driven Flexibility

Definition: There is an unwavering commitment to find a way to serve the community that may risk or go beyond self interest.

### How does one recognize and build this?

- An enduring and imaginative creative ability to see new resources, push the boundaries of convention, and think outside the box is evident.
- There is a willingness to let go, reframe objectives, and find different solutions to new issues that arise in the face of changing policy or structural barriers.

## Inclusivity

Definition: All partners and participants seek to honor different beliefs, values, and worldviews when acting as translators, brokers, advocates, and co-learners.

### How does one recognize and build this?

- Cultivate a culture where all partners feel they belong by fostering engagement with divergent perspectives.
- When navigating within and across diverse cultures and multiple sectors, there is continuous learning and teaching one another with recognition that we are never fully culturally competent.
- An intentional practice of individual and collective reflection is necessary to uncover personal and institutional biases and assumptions and their impact on the practice of assuring reach to vulnerable, at-risk, hard-to-reach, and minority populations.

### Case Example: Buddhist Tzu Chi Medical Foundation in Los Angeles

"Tzu Chi" means compassion and relief. The Tzu Chi Medical Foundation in Los Angeles has a long partnership relationship with the county health department and strong connections to other faith-based organizations, school systems, community centers, and social service agencies. To address the needs of hard-to-reach populations, Tzu Chi has built itself to be agile for work when and wherever people are best served. This always involves mobilizing large numbers of volunteers and includes setting up clinics in proximity to homeless shelters during hours when people are there or near work sites for migrant farmworkers before and after work hours.

The public health department recognizes the foundation as an important part of the "public health system" and includes it in preparedness planning processes and coordination of community outreach activities.

### Case Example: Center for Faith and Community Health Transformation in Chicago

Rev. Kirsten Peachey and Charles Williams, co-directors of the Center for Faith and Community Health Transformation, met with a group of leaders from Jewish health and social service agencies to explore ways that they might work together. They said to their hosts, "We use the terms 'faith and health' to describe our partnership activities, but don't know what that means for you."

In response, those representing the Jewish community said that the word "faith" was not what they would use to describe their work. What made more sense to them was "religious" as opposed to "faith-based."

Peachey and Williams approached the dialogue recognizing their own biases and acknowledging that they valued learning from a different tradition.

# Processes and Activities

This grouping of practices represents the activities that are essential to do the work on a day-to-day basis. They are what gets the work done in a way that is unique to the qualities faith-based partners bring in to the mix. These activities are often the best place to begin as you think about how to establish or expand a partnership.

## Identify Trusted Leaders

Definition: 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.

### How does one recognize and build this?

The leaders who are engaged:

- Are known to be motivated by the work itself—the needs of the community, ministry, purpose, call, and/or faith commitments.
- Know other trusted leaders and are able and willing to transfer and leverage that trust to and on behalf of others.
- Have relationships with one another and their communities through formal and informal networks and serve as trusted, influential messengers in those communities.
- Represent different sectors, levels of community leadership (grassroots and up), and can serve at different times and in different capacities as part of the collaborative work.

## Collaboration That Endures

Definition: Build partnerships and relationships that are not tied to specific health topics but are held together over time by the depth of long-term commitments to what can be accomplished together.

### How does one recognize and build this?

- Foster a collaborative culture that values what is done together as equal to or more important than what is done individually.
- Become adept at bi-directional organizational literacy; serve as a conduit that connects and aligns the strengths and priorities of diverse faith and health partners.
- Health partners can include health programming capacity building in grants and use their influence to leverage resources for FBO partners.

## Marry Stories With Data

Definition: Use a communication strategy that portrays personal stories contextualized to the particular culture and that showcase the human life and feeling embedded in the data. Human narrative is an important language of faith communities, a way that meaning and sense is made out of life.

### How does one recognize and build this?

- Ask people to tell their stories ("testimonies") at health events and capture those in print, audio, photo, or video.
- Present the human story in multiple venues and formats that are linguistically, spiritually, culturally, and geographically sensitive.
- Develop opportunities to hear the stories so people can see and feel how the health issue or behavior relates to them.
- Seek the story of the community, which conveys its journey and perhaps its future dream.

### Case Example: Lowell Community Health Center in Massachusetts

Lowell Community Health Center told this story along with the data representing those reached with influenza vaccinations:

Maristella is a gracious 76-year-old grandmother who goes to church every week and is beloved in her community. Last week at her church, Maristella met Julia and her colleagues from Lowell Community Health Center, who were offering flu shots to Maristella's congregation.

Maristella nosed around the table where the shots were being given and shared that she had never had a flu shot before. Maristella's insurance does not cover the cost, so she has never been able to afford one.

Since the health center's team knows the flu can be much more threatening to seniors, Julia helped Maristella apply for a program to cover the cost of not only the vaccine, but also all her healthcare needs. Fortunately, Maristella was approved for coverage and is thrilled to be receiving her very first vaccination at the age of 76.

# Processes and Activities

## Keep Relationships and Presence Paramount

Definition: Give diligent and visible attention to relationship building with communities and partners by giving time, being present, listening, and sharing power.

### How does one recognize and build this?

- Be in the community, go to the community, be a presence in the community, and accompany community leaders.
- Ample formal and informal occasions are built into the collaborative work for listening, development of a common vision, and shared decision making.
- Create spaces and interactions (meetings, informal conversations around the work, etc.) where people understand that their work can be an expression of their deepest values and faith commitments.
- Maintain contact as a year-round caring partner who is invested in the relationship beyond the specific issue being addressed. Be there "before, during, and after." Find a way to have staying power.

### Case Example: Penrose-St. Francis Health Services in Colorado Springs

In Colorado Springs, attention to building and maintaining a core set of partnership relationships results in expanded outreach to hard-to-reach persons and communities. These partners include Penrose-St. Francis Health Services; the University of Colorado, Colorado Springs Beth-El College of Nursing and Health Sciences; Westside Cares; the Latino American Health Network; and Mission Medical Clinic. The relationships among the five core partners yield a staying power in their collaboration and at their 14 community clinic sites. The relationships are intentionally built in service for the well-being of the community. Sharing their commitments and being present with one another is transferred to other community partners and to those they serve.

Throughout the year and every flu season, they return to sites that serve the homeless and low-income families. Their face-to-face contact at these clinics is more than a "grab and stab" model. Instead, they work to ensure that clinics are places of trust, respect, and dignity as well as sites for health prevention education.

## Build and Maintain Trust

Definition: Trust is primarily relational. It is built over time when respect for differences, commitment to the good of the community, integrity, and transparency are experienced consistently in the face of challenging collaborative endeavors.

### How does one recognize and build this?

- Demonstrate that this work is both an expression of both diverse faith commitments and shared concern for the well-being of all in the community.
- People want to know where you stand and don't want to be converted from what they believe. Show that you have your faith and respect theirs.
- Because people often implicitly trust religious leaders and faith-based services. This should be acknowledged and honored in the collaborative work.
- Trust is built within networks of partners when their priorities and the community's needs are met and yours are put aside.

### Case Example: Schuylkill County VISION in Pennsylvania

When the Interfaith Health Network of Schuylkill County was founded, congregations from various Christian denominations, the Muslim community, and the Sikh community all came to the table.

Convened by a creative local nonprofit called Schuylkill VISION, these diverse faith-based organizations built a partnership based on their commitment to the community and their faith-based motivation to love and serve. Selecting and focusing on a specific unmet priority that all partners agree to leads to a clear identity in the community and a clear call to action. The newly formed Schuylkill County Immunization Coalition brings a number of faith-based organizations, department of health members, community organizations, and others to the table together.

The mission that no one should die of an immunization-preventable disease in the county defines the work and the commitment to love and serve the community and forms the bedrock of these relationships.

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# Infrastructure

The following five practices represent the capacities and structures that both support the work and are built through ongoing collaborative activities. In other words, they support and grow through the activities and processes. Relationships and capacities that are built in a partnership are transferred to the relationships with the community and in turn replenish the collaboration.

## Leadership Anchors the Network

Definition: A leader is an individual or organization with an enduring commitment to the larger faith mission that takes or shares the primary role in sustaining and supporting the collective work of partners.

### How does one recognize and build this?

- They lead from a place of compassion and commitment to their partner leaders and the well-being of the community, creating an environment of mutual support, inspiration, and trust.
- They operate from a position of "power with" as an intermediary and stabilizer that keeps the network(s) connected and benefiting from the synergy of its interdependence.

### Case Example: A Faith-Based Health System in Chicago

In the search for responses to health disparities, one of the strategies government, academic, and healthcare organizations turn to is the idea of the "trusted messenger" to bring health information into communities where there are barriers to receiving care. Pastors and religious leaders are some of these trusted messengers. A faith-based healthcare system in Chicago took the lead to look honestly at this with their religious leader partners. We [Government, healthcare, and other health leaders] prepare sermon points, ask pastors to get their flu shot on a Sunday morning, prepare bulletin inserts, and set up clinics for screenings and education in church buildings.

The faith-based health system and their religious leader partners asked, "But what does it mean to be a 'trusted messenger' and is this the best possible partnership between faith communities and organizations promoting health?", and then took the step to convene African- American clergy to take a closer look at these kinds of questions. Are there more effective ways in which these critical barriers might be addressed by both the healthcare system and the African American community? How might the faith community shape what it means to be a "trusted messenger" on its own terms?

A key outcome of this project was that it brought together African-American clergy, religious leaders, and health leaders to consider the deeper dimensions of these trust issues and to explore how these issues can be addressed creatively and proactively to ensure the well-being of the community.

## Volunteers as Groundwork

Definition: Volunteers are often THE "workforce" of these efforts, adding relational and response capacity and service flexibility. Volunteers give because they care, want to serve, and want to make a difference. As much as they care, they must also be cared for and helped to see their impact.

### How does one recognize and build this?

- Quality training and preparation of volunteers includes standards of services and recognition of the value of their work and expression of "calling."
- Foster an alignment between volunteers and service providers that has synergy and sensitivity to the value-added contributions of both.
- Engage institutions and their intern programs to bolster capacity and to prepare the next generation for community-based work and service.

### Case Example: Fairview Health Services in Minneapolis

Pat Peterson at Fairview Health Services has built a very successful relationship with Homeland Health Specialists, Inc., which donates to and supports Fairview's large scale community immunization events with vaccinators.

Seeing the opportunity for more, Peterson created the opportunity for healthcare professionals from the hospital to volunteer on their own time to serve the community. She set up a volunteer registry and held trainings to prepare them to work in flu clinics.

In just one season, Fairview identified 136 potential volunteers and placed them in 76 volunteer positions, enabling them to expand the number of clinics by 36. Many gave up their weekend time to serve in the community.

# Infrastructure

## Circle of Core Partners

Definition: 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.

### How does one recognize and build this?

- Commitments of the core partners are institutionalized through covenants, memoranda of understanding, state ments of purpose, etc. but can be organic and renegotiated when resources, needs, and opportunities shift.
- Facing challenges and having staying power for long-term systemic change are supported by a structure of relationships that share a commitment to the faith mission (includes passion and what keeps you up at night).
- They recognize the gains of their alignment and are intentional about taking the time to identify and name their strengths, assets, and resources (seeing the best in each other).

### Case Example: Penrose-St. Francis Health Services Mission Outreach in Colorado Springs

In Colorado Springs, the successes of their flu immunization clinics are due to the strength and commitment of the partnership that has developed from the six years of immunization work starting with childhood immunization clinics in 2005. Their relationships have been intentionally built in service for the well-being of the community and their vision grounded in care.

Attention to building and maintaining a core set of partnership relationships results in expanded outreach to hard reach to persons and communities. These core partners include Penrose-St. Francis Health Services; the University of Colorado, Colorado Springs Beth-El College of Nursing and Health Sciences; Westside Cares; the Latino American Health Network; and Mission Medical Clinic.

Sharing their commitments over the years and being present with one another is transferred to other community partners and to those they serve. Together they have developed institutional reliability and respect within their own network and outward with the community.

## Network Connections

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

### How does one recognize and build this?

- Seek out and connect with established regional, state, national health and religious networks—alliances, consortia, denominations, organizations that are networks, councils, learning groups, resource centers, etc. Build in regular time for this kind of engagement!
- This connectivity makes it possible to increase access to additional resources, to learn, to avoid isolation, to promote your and others' work, and to share resources (make it a mutual endeavor).

### Case Example: United Health Organization in Detroit

Ifetayo Johnson, executive director of United Health Organization (UHO) in Detroit, pays very close attention to being connected across the city of Detroit and beyond. During the National Influenza Vaccination Week and Acacia Salatti, the deputy director of the HHS Center for Faith-Based and Neighborhood Partnerships, knew that Detroit was an important city for the Surgeon General to visit. In 2009, H1N1 immunization uptake had been very low in the African American community there. Salatti also had a relationship with Johnson and knew that she could count on her to pull together key leaders in the city. UHO has 45 years of experience, commitment, and trusted relationships, having led the effort each year to provide community-based health screenings to thousands of the uninsured and underinsured.

Johnson is the quintessential "trusted messenger" and drew on her connectivity to pull together elected officials, community members, health department leaders (county, city, and state), religious leaders, media, and healthcare leaders for the Surgeon General's visit. She took the opportunity to leverage much- needed health communication for this community and build further connectivity between the faith-based and health sectors.

The city health department did not waste any time in following up with Johnson to schedule numerous vaccination events at African-American churches in UHO's network.

# Infrastructure

## Multi-Sectoral Collaboration

Definition: Foster collaborative relationships and engage diverse groups to bring a wide variety of resources and commitments to bear on community health and well-being.

### How does one recognize and build this?

- Be visibly interfaith and model creating the space for different faith traditions and sectors to find common ground.
- Function as a portal that gives and fosters diverse access and partner points throughout the community.
- Be the one willing to try new things, go outside of your comfort zone, take risks, and connect with groups beyond the usual suspects.

### Case Example: Buddhist Tzu Chi Medical Foundation in Los Angeles

Debra Boudreaux, CEO of the Buddhist Tzu Chi Medical Foundation, has her eyes, ears, and heart on the lookout for populations that are beyond the radar and reach of others – the homeless, migrant farmworkers, disabled, . . . she has a lens of compassion that is always alert and engaged.

Once identified, an undeterred search is undertaken to partner with organizations that could assist as a partner in meeting those pressing needs. Over the years, the foundation has built relationships with school systems, community centers, businesses, chambers of commerce, YWCA, Head Start, parks and recreation, and others.

Their reach and service is accomplished with a vision of aligning with all those who care.

## Conclusion

Partnerships between public health and FBOs can be fruitful for both groups. As with any partnership, care and time must be given to these relationships. FBOs are trusted messengers to many people in the community who may not readily access or trust public health messages. Public health can be a source of information and resources to FBOs and their leadership, which they can in turn share with their congregations and those they serve in the community.

Public health programs should be diligent in approaching organizations that share similar commitments. Like any partnership, you cannot assume that relationship building and expansion are shared goals. Creating an interest in deepening the partnership may require some preliminary steps, such as convening introductory meetings to ensure proposed new/expanded activities are appropriately addressing common goals of both partners. Public health agencies may also consider distributing requests for proposals more widely to include FBOs.

We hope the Model Practices Framework has inspired you, affirmed what you are already doing, and given you the determination to do even better.

The last section has a list of organizations and resources that you may find useful as you continue on your partnership building journey.

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**HHS CENTER FOR FAITH-BASED AND NEIGHBORHOOD PARTNERSHIPS**
http://www.hhs.gov/partnerships/

**CENTER FOR FAITH AND COMMUNITY HEALTH TRANSFORMATION**
http://chicagofaithandhealth.org/

**CENTER OF EXCELLENCE IN FAITH AND HEALTH**
http://www.methodisthealth.org/about-us/faith-and-health/

**HEALTH MINISTRY ASSOCIATION**
http://hmassoc.org/

**CDC DOCUMENTS AND TOOLKITS**

- "Partnerships with faith-based & community-based organizations; engaging America's grass roots organizations in promoting public health" http://stacks.cdc.gov/view/cdc/11570
- "Preparing For The Flu: A Communication Toolkit for Community and Faith-Based Organizations" http://www.cdc.gov/h1n1flu/faithbased/pdf/H1N1_FBO_toolkit.pdf

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